New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

TABLE OF CONTENTS

New York City Health and Hospitals Corporation (PPS ID:52)

New York City Health and Hospitals Corporation (PPS ID:52)

New York City Health and Hospitals Corporation (PPS ID:52)

New York City Health and Hospitals Corporation (PPS ID:52)

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Quarterly Report - Implementation Plan for New York City Health and Hospitals Corporation

Year and Quarter: DY2, Q1 **Quarterly Report Status:** Adjudicated

Status By Section

Section	Description	Status
Section 01	Budget	Completed
Section 02	Governance	Completed
Section 03	Financial Stability	Completed
Section 04	Cultural Competency & Health Literacy	Completed
Section 05	IT Systems and Processes	Completed
Section 06	Performance Reporting	Completed
Section 07	Practitioner Engagement	Completed
Section 08	Population Health Management	Completed
Section 09	Clinical Integration	Completed
Section 10	General Project Reporting	Completed
Section 11	Workforce	Completed

Status By Project

Project ID	Project Title	Status
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	Completed
2.a.iii	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services	Completed
2.b.iii	ED care triage for at-risk populations	Completed
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	Completed
2.d.i	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care	Completed
3.a.i	Integration of primary care and behavioral health services	Completed
3.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)	Completed
3.d.ii	Expansion of asthma home-based self-management program	Completed
3.g.i	Integration of palliative care into the PCMH Model	Completed
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure across Systems	Completed
4.c.ii	Increase early access to, and retention in, HIV care	Completed

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 01 – Budget

IPQR Module 1.1 - PPS Budget - Waiver Revenue (Baseline) - READ ONLY

Instructions :

READ ONLY - The Baseline Budget table was left for ease of reference during reporting.

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	185,225,124	197,389,104	319,202,954	282,652,998	185,225,124	1,169,695,304
Cost of Project Implementation & Administration	**43,115,521**	**61,109,724**	**73,753,105**	**78,497,955**	**78,880,904**	**335,357,209**
Project Implementation	41,709,441	55,968,159	69,074,040	73,818,890	74,201,839	314,772,369
Administration	1,406,080	5,141,565	4,679,065	4,679,065	4,679,065	20,584,840
Revenue Loss	**0**	**13,449,415**	**40,348,245**	**40,348,245**	**40,348,245**	**134,494,150**
Internal PPS Provider Bonus Payments	**47,072,953**	**47,072,953**	**47,072,953**	**47,072,953**	**47,072,953**	**235,364,765**
Cost of non-covered services	**1,774,992**	**27,994,914**	**63,214,463**	**125,718,491**	**128,806,788**	**347,509,648**
Other	**18,522,512**	**19,738,910**	**31,920,295**	**28,265,300**	**18,522,512**	**116,969,529**
Contingency Fund	18,522,512	19,738,910	31,920,295	28,265,300	18,522,512	116,969,529
Total Expenditures	**110,485,978**	**169,365,916**	**256,309,061**	**319,902,944**	**313,631,402**	**1,169,695,301**
Undistributed Revenue	**74,739,146**	**28,023,188**	**62,893,893**	**0**	**0**	**3**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

When compared with the approach articulated in the OneCity Health DSRIP application, budget estimates set out here reflect relative higher percentages for Project Implementation Costs and Costs for Services Not Covered, and lower relative percentages for the Revenue Loss and Bonus Pool categories. This variance stems from a variety of factors:

1. These estimates reflect costs net of Inter-governmental Transfers (IGT).

2. The budget estimates set out here are based on the most recent projections of resources required to fulfill the state mandated project requirements and performance targets and successfully achieve the objectives outlined in OneCity Health's DSRIP application. These estimates

New York City Health and Hospitals Corporation (PPS ID:52)

were built upon individual workflows within the DSRIP projects, focusing on Project Implementation Costs and Costs for Uncovered Services. The estimates are preliminary and will continue to evolve as the PPS works with its partners to better understand program and implementation requirements.

3. These estimates take into account OneCity Health's maximum total valuation figures communicated by the DOH on May 7th, which reflected a lower amount than anticipated given the proportion of New York State Medicaid patients served by OneCity Health.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 1.2 - PPS Budget - Waiver Revenue (Quarterly)

Instructions :

Please include updates on waiver revenue budget items for this quarterly reporting period. Reported actual spending will be compared to baseline projections and deviations will be evaluated. Any explanations regarding deviations from baseline projections must be included within the textbox, not as narrative within uploaded documentation.

Benchmarks

Waiver Revenue DY2	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
197,389,104	1,169,695,304	195,024,317	1,156,706,961

Budget Items	DY2 Q1 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**2,186,177**	**12,809,733**	**58,923,547**	**96.42%**	**322,547,476**	**96.18%**
Project Implementation	1,036,044					
Administration	1,150,133					
Revenue Loss	**0**	**0**	**13,449,415**	**100.00%**	**134,494,150**	**100.00%**
Internal PPS Provider Bonus Payments	**178,610**	**178,610**	**46,894,343**	**99.62%**	**235,186,155**	**99.92%**
Cost of non-covered services	**0**	**0**	**27,994,914**	**100.00%**	**347,509,648**	**100.00%**
Other	**0**	**0**	**19,738,910**	**100.00%**	**116,969,529**	**100.00%**
Contingency Fund	0					
Total Expenditures	**2,364,787**	**12,988,343**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Expenditures reported this quarter covered OneCity Health efforts to finalize Phase 1 contracting that included issuing contracts (Schedules B) to approximately 185 PPS partners covering the period through March 2017. Payments to partners totaled $240k and were primarily for participation in Project 11 (2.d.i) and for completing the Master Partner Data Survey (a prerequisite for developing Phase 1 contracts). OneCity Health continues to receive invoices for work completed in previous quarters.

Administration expenses include strategic planning for and roll out of Phase 1 contracts to partners. Project Implementation expenses include supporting initiatives under project 2.a.i such as technical support to community primary care practices for PCMH Level 3 certification; Domain 4 Mental Health and Substance Abuse (4.a.iii) project expenses, for which a lead implementer was funded via a PPS collaborative; start-up payments to partners; and the implementation of a care coordination platform for partners.

PPS Provider Bonus Payments include funds distributed to partners for participation in Project 11 and for completing the Master Partner Data Survey.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 1.3 - PPS Flow of Funds - Waiver Revenue (Baseline) - READ ONLY

Instructions :

READ ONLY - The Baseline Funds Flow table was left for ease of reference during reporting.

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	185,225,124	197,389,104	319,202,954	282,652,998	185,225,124	1,169,695,304
Practitioner - Primary Care Provider (PCP)	2,793,672	3,956,250	5,593,429	7,533,332	7,632,017	27,508,700
Practitioner - Non-Primary Care Provider (PCP)	2,722,351	3,615,736	4,913,670	6,225,573	6,291,970	23,769,300
Hospital	43,432,337	65,905,162	100,089,247	110,428,031	111,085,607	430,940,384
Clinic	10,239,448	16,379,860	23,776,469	34,094,212	34,633,948	119,123,937
Case Management / Health Home	8,479,864	23,830,873	43,886,791	78,852,633	80,583,457	235,633,618
Mental Health	10,540,612	13,814,253	18,142,181	22,105,922	22,287,652	86,890,620
Substance Abuse	1,412,189	1,815,671	2,622,636	2,622,636	2,622,636	11,095,768
Nursing Home	3,672,802	5,205,388	7,365,003	7,924,029	7,942,239	32,109,461
Pharmacy	1,412,189	1,412,189	1,412,189	1,412,189	1,412,189	7,060,945
Hospice	1,148,913	1,675,936	2,458,315	2,626,023	2,631,486	10,540,673
Community Based Organizations	4,703,010	6,874,122	9,449,772	13,134,000	13,306,625	47,467,529
All Other	18,522,512	19,738,910	31,920,295	28,265,300	18,522,512	116,969,529
Uncategorized						0
PPS PMO	1,406,080	5,141,565	4,679,065	4,679,065	4,679,065	20,584,840
Total Funds Distributed	**110,485,979**	**169,365,915**	**256,309,062**	**319,902,945**	**313,631,403**	**1,169,695,304**
Undistributed Revenue	**74,739,145**	**28,023,189**	**62,893,892**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

The forecast funds flow set out here is consistent with the approach to the distribution of DSRIP funds articulated in the OneCity Health DSRIP application. However it should be noted that the "Hospitals" and "Clinics" categories include primary care physicians, non-PCP practitioners, behavioral health providers, etc., who are employed by HHC or SUNY. In addition, the "Health Home/Care Management" category is assumed to incorporate several provider classes engaged in the provision of care management services.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 1.4 - PPS Flow of Funds - Waiver Revenue (Quarterly)

Instructions :

Please include updates on waiver revenue flow of funds for this quarterly reporting period by importing the PIT file and filling out the PPS PMO line manually. Reported actual fund distribution will be compared to baseline projections and deviations will be evaluated. Any explanations regarding deviations from baseline projections must be included within the textbox, not as narrative within uploaded documentation.

Benchmarks

Waiver Revenue DY2	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
197,389,104.00	1,169,695,304.00	195,024,318.02	1,156,706,962.02

Funds Flow Items	DY2 Q1 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q1 Quarterly Amount - Update	Safety Net Funds Flowed YTD	Safety Net Funds Percentage YTD	Total Amount Disbursed to Date (DY1-DY5)	Percent Spent By Project											DY Adjusted Difference	Cumulative Difference
						Projects Selected By PPS												
						2.a.i	2.a.iii	2.b.iii	2.b.iv	2.d.i	3.a.i	3.b.i	3.d.ii	3.g.i	4.a.iii	4.c.ii		
Practitioner - Primary Care Provider (PCP)	1,256.06	100.00%	1,256.06	100.00%	1,256.06	24.24	0	0	0	75.76	0	0	0	0	0	0	3,954,993.94	27,507,443.94
Practitioner - Non-Primary Care Provider (PCP)	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0	0	3,615,736	23,769,300
Hospital	12,666.67	100.00%	12,666.67	100.00%	12,666.67	29.19	0	0	0	70.81	0	0	0	0	0	0	65,892,495.33	430,927,717.33
Clinic	25,802.56	100.00%	25,802.56	100.00%	25,802.56	16	0	0	0	84	0	0	0	0	0	0	16,354,057.44	119,098,134.44
Case Management / Health Home	19,393.75	54.95%	10,656.01	54.95%	19,393.75	74.22	0	0	0	25.78	0	0	0	0	0	0	23,811,479.25	235,614,224.25
Mental Health	8,851.27	92.69%	8,204.57	92.69%	8,851.27	49.1	0	0	0	50.9	0	0	0	0	0	0	13,805,401.73	86,881,768.73
Substance Abuse	553.73	100.00%	553.73	100.00%	553.73	100	0	0	0	0	0	0	0	0	0	0	1,815,117.27	11,095,214.27
Nursing Home	2,588.08	100.00%	2,588.08	100.00%	2,588.08	100	0	0	0	0	0	0	0	0	0	0	5,202,799.92	32,106,872.92
Pharmacy	199.19	100.00%	199.19	100.00%	199.19	29.19	0	0	0	70.81	0	0	0	0	0	0	1,411,989.81	7,060,745.81
Hospice	282.70	25.53%	72.17	25.53%	282.70	100	0	0	0	0	0	0	0	0	0	0	1,675,653.30	10,540,390.30
Community Based Organizations	88,515.50	0.00%	0	0.00%	118,515.50	19.88	0	0	0	80.12	0	0	0	0	0	0	6,785,606.50	47,349,013.50
All Other	61,253.47	88.28%	54,071.52	88.28%	61,253.47	39.26	0	0	0	60.74	0	0	0	0	0	0	19,677,656.53	116,908,275.53
Uncategorized	15,647	18.20%	2,847	18.20%	20,647	92.03	0	0	0	7.97	0	0	0	0	0	0	0	0
Additional Providers	1,600	0.00%	0	0.00%	1,600													
PPS PMO	2,126,176	100.00%	2,126,176	100.00%	12,714,732												3,015,389	7,870,108
Total	**2,364,785.98**	**94.94%**	**2,245,093.56**	**94.94%**	**12,988,341.98**													

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 1.5 - Prescribed Milestones

Instructions :

Please provide updates to baseline target dates and work breakdown tasks with target dates for required milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement. Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Completed	Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task Step 1: Conduct detailed survey/assessment of existing partner resources and capabilities.	Completed	Step 1: Conduct detailed survey/assessment of existing partner resources and capabilities.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Define project-level requirements by provider type through a hub-based planning process.	Completed	Step 2: Define project-level requirements by provider type through a hub-based planning process.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Engage in partner contracting process through execution of Master Services Agreement and begin execution of project-specific schedules on a rolling basis in accordance with project initiation timeline.	Completed	Step 3: Engage in partner contracting process through execution of Master Services Agreement and begin execution of project-specific schedules on a rolling basis in accordance with project initiation timeline.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4: Draft PPS Budget and Funds Flow distribution plan.	Completed	Step 4: Draft PPS Budget and Funds Flow distribution plan.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: Review and recommendation of PPS Budget and Funds Flow distribution plan by Business Operations & Information Technology Subcommittee.	Completed	Step 5: Review and recommendation of PPS Budget and Funds Flow distribution plan by Business Operations & Information Technology Subcommittee.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6: Review and approval of PPS Budget and Funds Flow distribution plan by PPS Executive	Completed	Step 6: Review and approval of PPS Budget and Funds Flow distribution plan by PPS Executive Committee.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Committee.									

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Complete funds flow budget and distribution plan and communicate with network	chengc2	Templates	52_DY2Q1_BDGT_MDL15_PRES1_TEMPL_Meeting_Schedule_Template_5603.xlsx	OneCity Health Meeting Schedule Template	08/05/2016 11:01 AM
	jwarrick	Documentation/Certification	52_DY2Q1_BDGT_MDL15_PRES1_DOC_OCH_Funds_Flow_Budget_and_Distribution_Plan_20160723_vf_5454.pdf	OneCity Health Funds Flow Budget and Distribution Plan	08/04/2016 04:02 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Complete funds flow budget and distribution plan and communicate with network	OneCity Health's funds flow and distribution plan outlines the methodology through which funds are distributed to partners for achieving DSRIP-related milestones. The PPS is employing a phased approach to contracting and funds flow that allows for learning about project implementation, partner capabilities and interest, market drivers, and patient flow between projects and partners. Each phase of contracting is funded on the basis of a five-year PPS funds flow model. Phase 1 of contracting, which runs through March 31, 2017, involves paying partners for completing a Master Partner Data Survey and engaging in several distinct project Schedules B (contracts) as well as a Comprehensive Schedule B covering eight projects. Most metrics in Phase 1 are for reporting. Phase 2 of contracting will begin April 1, 2017 and will follow the DSRIP model and move toward value-based payments and shared risk. OneCity has been actively engaging partners in developing contracting methodologies through a variety of communication channels, including webinars and newsletters, individual calls and meetings, as well as through the PPS governance. Please see the attached Funds Flow Budget and Distribution Plan for more details. The attached meeting template lists the dates of the Business Operations and IT Committee and Executive Committee meetings that reviewed and approved the contracting and funds flow methodologies as well as the dates of two webinars dedicated to the Comprehensive Schedule B.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 1.6 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 1.7 - PPS Budget - Non-Waiver Revenue (Baseline)

Instructions :

This table contains five budget categories for non-waiver revenue baseline budget reporting . Please add rows to this table as necessary in order to identify sub-categories.

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Non-Waiver Revenue	0	0	0	0	0	0
Cost of Project Implementation & Administration	**0**	**0**	**0**	**0**	**0**	**0**
Administration	0	0	0	0	0	0
Implementation	0	0	0	0	0	0
Revenue Loss	**0**	**0**	**0**	**0**	**0**	**0**
Internal PPS Provider Bonus Payments	**0**	**0**	**0**	**0**	**0**	**0**
Cost of non-covered services	**0**	**0**	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**	**0**	**0**
Total Expenditures	**0**	**0**	**0**	**0**	**0**	**0**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 1.8 - PPS Budget - Non-Waiver Revenue (Quarterly)

Instructions :

Please include updates on non-waiver revenue budget items for this quarterly reporting period. Reported actual spending will be compared to baseline projections and deviations will be evaluated. Any explanations regarding deviations from baseline projections must be included within the textbox, not as narrative within uploaded documentation.

Benchmarks

Non-Waiver Revenue DY2	Total Non-Waiver Revenue	Undistributed Non-Waiver Revenue YTD	Undistributed Non-Waiver Revenue Total
0	0	0	0

Budget Items	DY1 Amount - Update	DY2 Q1 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**0**	**0**	**0**	**0**		**0**	
Administration	0	0					
Implementation	0	0					
Revenue Loss	**0**	**0**	**0**	**0**		**0**	
Internal PPS Provider Bonus Payments	**0**	**0**	**0**	**0**		**0**	
Cost of non-covered services	**0**	**0**	**0**	**0**		**0**	
Other	**0**	**0**	**0**	**0**		**0**	
Total Expenditures	**0**	**0**	**0**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 1.9 - PPS Flow of Funds - Non-Waiver Revenue (Baseline)

Instructions :

In the table below, please detail your PPS's projected flow of non-waiver funds by provider type.

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Non-Waiver Revenue	0	0	0	0	0	0
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0
Hospital	0	0	0	0	0	0
Clinic	0	0	0	0	0	0
Case Management / Health Home	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0
Substance Abuse	0	0	0	0	0	0
Nursing Home	0	0	0	0	0	0
Pharmacy	0	0	0	0	0	0
Hospice	0	0	0	0	0	0
Community Based Organizations	0	0	0	0	0	0
All Other	0	0	0	0	0	0
Uncategorized	0	0	0	0	0	0
PPS PMO	0	0	0	0	0	0
Total Funds Distributed	**0**	**0**	**0**	**0**	**0**	**0**
Undistributed Non-Waiver Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 1.10 - PPS Flow of Funds - Non-Waiver Revenue (Quarterly)

Instructions :

Please include updates on flow of funds for this quarterly reporting period by importing the PIT file and filling out the PPS PMO line manually. Reported actual fund distribution will be compared to baseline projections and deviations will be evaluated.
Any explanations regarding deviations from baseline projections must be included within the textbox, not as narrative within uploaded documentation.

Benchmarks

Non-Waiver Revenue DY2	Total Non-Waiver Revenue	Undistributed Non-Waiver Revenue YTD	Undistributed Non-Waiver Revenue Total
0.00	0.00	0.00	0.00

Funds Flow Items	DY1 Amount - Update	DY2 Q1 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q1 Quarterly Amount - Update	Safety Net Funds Flowed YTD	Safety Net Funds Percentage YTD	Total Amount Disbursed to Date (DY1-DY5)	DY Adjusted Difference	Cumulative Difference
Practitioner - Primary Care Provider (PCP)	0	0	0.00%	0	0.00%	0	0	0
Practitioner - Non-Primary Care Provider (PCP)	0	0	0.00%	0	0.00%	0	0	0
Hospital	0	0	0.00%	0	0.00%	0	0	0
Clinic	0	0	0.00%	0	0.00%	0	0	0
Case Management / Health Home	0	0	0.00%	0	0.00%	0	0	0
Mental Health	0	0	0.00%	0	0.00%	0	0	0
Substance Abuse	0	0	0.00%	0	0.00%	0	0	0
Nursing Home	0	0	0.00%	0	0.00%	0	0	0
Pharmacy	0	0	0.00%	0	0.00%	0	0	0
Hospice	0	0	0.00%	0	0.00%	0	0	0
Community Based Organizations	0	0	0.00%	0	0.00%	0	0	0
All Other	0	0	0.00%	0	0.00%	0	0	0
Uncategorized	0	0	0.00%	0	0.00%	0	0	0

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Funds Flow Items	DY1 Amount - Update	DY2 Q1 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q1 Quarterly Amount - Update	Safety Net Funds Flowed YTD	Safety Net Funds Percentage YTD	Total Amount Disbursed to Date (DY1-DY5)	DY Adjusted Difference	Cumulative Difference
Additional Providers	0	0	0.00%	0	0.00%	0		
PPS PMO	1	0	0.00%	0	0.00%	1	0	0
Total	**1**	**0**		**0**		**1**		

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

IA, please return this module during the remediation period.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 1.11 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 02 – Governance

IPQR Module 2.1 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	Completed	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	YES
Task Step 1: Appoint members of the PPS Executive Committee.	Completed	Step 1: Appoint members of the PPS Executive Committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2: Convene PPS Executive Committee and initiate committee work.	Completed	Step 2: Convene PPS Executive Committee and initiate committee work.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 3: Develop and finalize charters for PPS Executive Committee, Nominating Committee, Care Models Subcommittee, Stakeholder & Patient Engagement Subcommittee, Business Operations & Information Technology Subcommittee, and Hub Steering Committees (collectively, the "Governance Charters"). The Governance Charters will describe the responsibilities of each committee, the process for appointing members to each committee, and the consensus-based decision making process of each committee.	Completed	Step 3: Develop and finalize charters for PPS Executive Committee, Nominating Committee, Care Models Subcommittee, Stakeholder & Patient Engagement Subcommittee, Business Operations & Information Technology Subcommittee, and Hub Steering Committees (collectively, the "Governance Charters"). The Governance Charters will describe the responsibilities of each committee, the process for appointing members to each committee, and the consensus-based decision making process of each committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 4: PPS Executive Committee and HHC will approve all Governance Charters.	Completed	Step 4: PPS Executive Committee and HHC will approve all Governance Charters.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task	Completed	Step 5: Appoint initial members of the Nominating Committee,	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 5: Appoint initial members of the Nominating Committee, Care Models Subcommittee, Stakeholder & Patient Engagement Subcommittee, Business Operations & Information Technology Subcommittee, and Hub Steering Committees (collectively, the "Subcommittees"). The Hub Steering Committees will be responsible providing local leadership of DSRIP-related activities and reporting back to the PPS-wide committees on local issues and best practices. Appoint Compliance Officer (within HHC Compliance function).		Care Models Subcommittee, Stakeholder & Patient Engagement Subcommittee, Business Operations & Information Technology Subcommittee, and Hub Steering Committees (collectively, the "Subcommittees"). The Hub Steering Committees will be responsible providing local leadership of DSRIP-related activities and reporting back to the PPS-wide committees on local issues and best practices. Appoint Compliance Officer (within HHC Compliance function).							
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1: Develop and finalize charter for Care Models Subcommittee. The charter will describe the responsibilities of the Care Models Subcommittee, the process for appointing members to the Care Models Subcommittee, and the consensus-based decision making process of the Care Models Subcommittee. PPS Executive Committee and HHC will approve the charter. The Care Models Subcommittee will provide clinical governance and quality oversight for all DSRIP projects in conjunction with the PPS Chief Clinical Officer.	Completed	Step 1: Develop and finalize charter for Care Models Subcommittee. The charter will describe the responsibilities of the Care Models Subcommittee, the process for appointing members to the Care Models Subcommittee, and the consensus-based decision making process of the Care Models Subcommittee. PPS Executive Committee and HHC will approve the charter. The Care Models Subcommittee will provide clinical governance and quality oversight for all DSRIP projects in conjunction with the PPS Chief Clinical Officer.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Solicit and appoint members of the Care Models Subcommittee.	Completed	Step 2: Solicit and appoint members of the Care Models Subcommittee.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Convene Care Models Subcommittee, review charter, and initiate Care Models Subcommittee work.	Completed	Step 3: Convene Care Models Subcommittee, review charter, and initiate Care Models Subcommittee work.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 4: Develop and finalize initial clinical guidelines for each project based on recommendations of ad-hoc project-specific Clinical Leadership Team workgroups. Review of guidelines by Care Models Subcommittee, Project Advisory Committee, and Executive Committee. Care Models Committee will further refine clinical guidelines over time, convening ad-hoc sub-workgroups as needed.	Completed	Step 4: Develop and finalize initial clinical guidelines for each project based on recommendations of ad-hoc project-specific Clinical Leadership Team workgroups. Review of guidelines by Care Models Subcommittee, Project Advisory Committee, and Executive Committee. Care Models Committee will further refine clinical guidelines over time, convening ad-hoc sub-workgroups as needed.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5: Appoint PPS Chief Clinical Officer.	Completed	Step 5: Appoint PPS Chief Clinical Officer.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 6: Develop and finalize initial clinical guidelines for each project. Care Models Subcommittee and Executive Committee will approve clinical guidelines.	Completed	Step 6: Develop and finalize initial clinical guidelines for each project. Care Models Subcommittee and Executive Committee will approve clinical guidelines.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7: Establish process and schedule to review and revise/update clinical guidelines on an as needed basis.	Completed	Step 7: Establish process and schedule to review and revise/update clinical guidelines on an as needed basis.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Completed	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1: Develop and finalize approval of Governance Charters, which are the functional equivalent of by-laws and Committee Guidelines for the PPS governance structure.	Completed	Step 1: Develop and finalize approval of Governance Charters, which are the functional equivalent of by-laws and Committee Guidelines for the PPS governance structure.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2: Share Governance Charters with other Subcommittees and partner organizations.	Completed	Step 2: Share Governance Charters with other Subcommittees and partner organizations.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Establish process to review and revise/update Charters on an annual or as needed basis.	Completed	Step 3: Establish process to review and revise/update Charters on an annual or as needed basis.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4	Completed	This milestone must be completed by 12/31/2015.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Establish governance structure reporting and monitoring processes		Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes.							
Task Step 1: Draft procedures by which the PPS Executive Committee and Subcommittees will (a) keep minutes, (b) send minutes and supporting meeting materials to the Executive Committee, other Subcommittees, as applicable, and (c) make minutes, and meeting materials, as appropriate, available to partner organizations ("Reporting Process").	Completed	Step 1: Draft procedures by which the PPS Executive Committee and Subcommittees will (a) keep minutes, (b) send minutes and supporting meeting materials to the Executive Committee, other Subcommittees, as applicable, and (c) make minutes, and meeting materials, as appropriate, available to partner organizations ("Reporting Process").	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Establish electronic governance portal to post minutes from Executive Committee and Subcommittees.	Completed	Step 2: Establish electronic governance portal to post minutes from Executive Committee and Subcommittees.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3: Establish process to monitor and revise Reporting Process as needed to ensure effective governance of PPS.	Completed	Step 3: Establish process to monitor and revise Reporting Process as needed to ensure effective governance of PPS.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	In Progress	Community engagement plan, including plans for two-way communication with stakeholders.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: Determine which types of organizations benefit from PPS engagement at a hub-level vs. a City-wide level.	In Progress	Step 1: Determine which types of organizations benefit from PPS engagement at a hub-level vs. a City-wide level.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 2: For hub-level engagement targets, identify existing engagement channels between hub partners (e.g., hospitals, FQHCs, CBOs) and public/non-provider organizations, including the feasibility of leveraging those channels for PPS engagement.	In Progress	Step 2: For hub-level engagement targets, identify existing engagement channels between hub partners (e.g., hospitals, FQHCs, CBOs) and public/non-provider organizations, including the feasibility of leveraging those channels for PPS engagement.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task	In Progress	Step 3: Segment remaining other public and non-provider	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 3: Segment remaining other public and non-provider organizations by most appropriate two-way engagement channel (e.g., in-person forums, web portal).		organizations by most appropriate two-way engagement channel (e.g., in-person forums, web portal).							
Task Step 4: Design Community Engagement Plan, including two-way communication with stakeholder groups and accounting for hub-level and City-wide level engagement needs.	In Progress	Step 4: Design Community Engagement Plan, including two-way communication with stakeholder groups and accounting for hub-level and City-wide level engagement needs.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 5: Community Engagement Plan reviewed and recommended by Stakeholder & Patient Engagement Subcommittee.	In Progress	Step 5: Community Engagement Plan reviewed and recommended by Stakeholder & Patient Engagement Subcommittee.	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 6: Community Engagement plan reviewed and approved by PPS Executive Committee.	In Progress	Step 6: Community Engagement plan reviewed and approved by PPS Executive Committee.	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Milestone #6 Finalize partnership agreements or contracts with CBOs	Completed	Signed CBO partnership agreements or contracts.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1: Draft Master Services Agreement and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure (collectively, the "Base Agreement").	Completed	Step 1: Draft Master Services Agreement and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure (collectively, the "Base Agreement").	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Solicit comments from partners.	Completed	Step 2: Solicit comments from partners.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Finalize Base Agreement.	Completed	Step 3: Finalize Base Agreement.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4: Execute Base Agreements.	Completed	Step 4: Execute Base Agreements.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Begin development and execution of first project-specific schedules for certain partners, as appropriate, in accordance with project initiation timeline.	Completed	Step 5: Begin development and execution of first project-specific schedules for certain partners, as appropriate, in accordance with project initiation timeline.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task	Completed	Step 6: Execute agreements.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 6: Execute agreements.									
Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Completed	Agency Coordination Plan.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Identify key public sector agency stakeholders not already affiliated with the OneCity Health PPS Project Advisory Committee (PAC) or other governance structures.	Completed	Step 1: Identify key public sector agency stakeholders not already affiliated with the OneCity Health PPS Project Advisory Committee (PAC) or other governance structures.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Conduct series of discussions with key leaders not already in close affiliation with OneCity Health to identify the full range of collaboration opportunities across programs.	Completed	Step 2: Conduct series of discussions with key leaders not already in close affiliation with OneCity Health to identify the full range of collaboration opportunities across programs.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Create Agency Coordination Plan.	Completed	Step 3: Create Agency Coordination Plan.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Agency Coordination Plan reviewed and recommended by Stakeholder & Patient Engagement Subcommittee.	Completed	Step 4: Agency Coordination Plan reviewed and recommended by Stakeholder & Patient Engagement Subcommittee.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: Agency Coordination Plan reviewed and approved by PPS Executive Committee.	Completed	Step 5: Agency Coordination Plan reviewed and approved by PPS Executive Committee.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #8 Finalize workforce communication and engagement plan	In Progress	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee).	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: Based on current state workforce assessment report & gap analysis, and training strategy, as well as overall PPS project implementation strategy, identify key elements and timing of workforce communication and engagement plan.	In Progress	Step 1: Based on current state workforce assessment report & gap analysis, and training strategy, as well as overall PPS project implementation strategy, identify key elements and timing of workforce communication and engagement plan.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 2: Leverage the Hub-based PPS structure to identify local workforce communication needs, building on existing stakeholder constituency groups such as the HHC Speakers Bureau; hub-specific communication needs will depend on pace and timing of DSRIP project implementation in each area.	In Progress	Step 2: Leverage the Hub-based PPS structure to identify local workforce communication needs, building on existing stakeholder constituency groups such as the HHC Speakers Bureau; hub-specific communication needs will depend on pace and timing of DSRIP project implementation in each area.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3: Develop workforce communication and engagement plan in collaboration with labor union partners and other stakeholders, with focus on key changes anticipated as part of DSRIP program implementation as well as key features of PPS workforce strategy. Revise plan on an ongoing basis in collaboration with stakeholders.	In Progress	Step 3: Develop workforce communication and engagement plan in collaboration with labor union partners and other stakeholders, with focus on key changes anticipated as part of DSRIP program implementation as well as key features of PPS workforce strategy. Revise plan on an ongoing basis in collaboration with stakeholders.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 4: Present workforce communication and engagement plan to PPS Executive Committee for review and approval.	In Progress	Step 4: Present workforce communication and engagement plan to PPS Executive Committee for review and approval.	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	
Milestone #9 Inclusion of CBOs in PPS Implementation.	In Progress	Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: CBO outreach and engagement to better understand how existing scope(s) of service relate to community need and align with programmatic interventions across patient settings. Engagement activities to-date include: - CBO Townhall Meetings (webinars) - General and project-focused meetings with CBO delegations - PPS PAC meetings with broad CBO participation	Completed	Step 1: CBO outreach and engagement to better understand how existing scope(s) of service relate to community need and align with programmatic interventions across patient settings. Engagement activities to-date include: - CBO Townhall Meetings (webinars) - General and project-focused meetings with CBO delegations - PPS PAC meetings with broad CBO participation	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	Completed	Step 2: Develop Partner Readiness Assessment Tool	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 2: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on PPS network capacity and capabilities, including CBOs. Educate CBO partners on PRAT via webinar; provide ongoing phone-based support as needed.		(PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on PPS network capacity and capabilities, including CBOs. Educate CBO partners on PRAT via webinar; provide ongoing phone-based support as needed.							
Task Step 3: Develop inclusive PPS governance structure with range of partner types and expertise, with CBO representation on each governance committee.	Completed	Step 3: Develop inclusive PPS governance structure with range of partner types and expertise, with CBO representation on each governance committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 4: Hire Senior Director of Engagement and Collaborations, who has primary responsibility of facilitating design and implementation of cultural competency programming, and for the oversight of CBO and other partner participation in achieving Project 11 program goals.	Completed	Step 4: Hire Senior Director of Engagement and Collaborations, who has primary responsibility of facilitating design and implementation of cultural competency programming, and for the oversight of CBO and other partner participation in achieving Project 11 program goals.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 5: Solicit feedback and questions from CBOs on Master Services Agreements and exhibits (collectively, the "Base Agreement") and finalize agreement.	Completed	Step 5: Solicit feedback and questions from CBOs on Master Services Agreements and exhibits (collectively, the "Base Agreement") and finalize agreement.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 6: Execute Base Agreements with ~65 CBOs.	Completed	Step 6: Execute Base Agreements with ~65 CBOs.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7: Care Models Committee, including CBO representation, will define key measures for early implementation activities.	Completed	Step 7: Care Models Committee, including CBO representation, will define key measures for early implementation activities.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8: Meet with select CBOs in series of meetings to understand the full range of programs in which organizations may participate in OneCity Health DSRIP programs.	Completed	Step 8: Meet with select CBOs in series of meetings to understand the full range of programs in which organizations may participate in OneCity Health DSRIP programs.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 9: Educate CBOs about Patient Activation Measure tool, inventory existing patient activation resources, and develop training and implementation plan for both technology and patient coaching.	Completed	Step 9: Educate CBOs about Patient Activation Measure tool, inventory existing patient activation resources, and develop training and implementation plan for both technology and patient coaching.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description
Finalize governance structure and sub-committee structure	If there have been changes, please describe those changes and upload any supporting documentation as necessary.	Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box.
Finalize bylaws and policies or Committee Guidelines where applicable	If there have been changes, please describe those changes and upload any supporting documentation as necessary.	Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box.

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize governance structure and sub-committee structure	jwarrick	Templates	52_DY2Q1_GOV_MDL21_PRES1_TEMPL_OneCity_Health_Governance_Committee_Members_DY2Q1_4825.xlsx	OneCity Health Governance Committee Member Template DY2 Q1	08/02/2016 02:29 PM
	jwarrick	Templates	52_DY2Q1_GOV_MDL21_PRES1_TEMPL_OneCity_Health_Governance_Committee_Meeting_Schedule_Template_DY2Q1_4824.xlsx	OneCity Health Governance Committee Schedule Template DY2 Q1	08/02/2016 02:28 PM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	jwarrick	Templates	52_DY2Q1_GOV_MDL21_PRES2_TEMPL_OneCity_Health_Care_Models_Committee_Meeting_Schedule_DY2Q1_5020.xlsx	OneCity Health Care Models Committee Meeting Schedule DY2Q1	08/03/2016 11:54 AM
	jwarrick	Templates	52_DY2Q1_GOV_MDL21_PRES2_TEMPL_OneCity_Health_Clinical_Governance_Committee_DY2Q1_5018.xlsx	OneCity Health Clinical Governance Committee DY2 Q1	08/03/2016 11:51 AM
Finalize partnership agreements or contracts with CBOs	chengc2	Templates	52_DY2Q1_GOV_MDL21_PRES6_TEMPL_OneCity_Health_DY2_Q1_CBO_Template_5288.xlsx	OneCity Health DY2 Q1 Community Based Organizations Template	08/04/2016 10:17 AM
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of	wy622871	Templates	52_DY2Q1_GOV_MDL21_PRES7_TEMPL_Public_Sector_Agency_Template_5620.xlsx	Public Sector Agency Template	08/05/2016 11:34 AM

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
health and mental hygiene, Social Services, Corrections, etc.)	chengc2	Other	52_DY2Q1_GOV_MDL21_PRES7_OTH_OneCity_Health_PPS_Agency_Coordination_Plan_vf_5050.pdf	Agency Coordination Plan	08/03/2016 01:55 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	No, there are no organization chart updates at this time.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	No, there are no organization chart updates at this time.
Finalize bylaws and policies or Committee Guidelines where applicable	No, there are no updates at this time.
Establish governance structure reporting and monitoring processes	No, there are no updates at this time.
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	
Finalize partnership agreements or contracts with CBOs	The template, "Community Based Organizations" is attached.
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	The goal of the OneCity Health Agency Coordination Plan is to engage appropriate public sector agencies at the state and local levels in ongoing DSRIP transformation efforts. The Agency Coordination Plan lists involved agencies (e.g., New York City Department for the Aging, New York City Department of Health and Mental Hygiene, etc.) and segments the nature of the relationship into primary areas of expertise such as behavioral health, care management, or other services and describes the collaboration purposes of each agency. OneCity Health collaborated with public agencies based on the alignment between each agency's scope of work and the PPS's projects and/or organizational work streams. In general, public sector agencies within the OneCity Health network serve two main roles: 1) to provide subject matter expertise, or 2) to provide direct services. Two examples of public agency engagement include the involvement of the Department of Education to provide educational resources in the school-based mental health and substance abuse (MHSA) project (4.a.iii) and the involvement of the Office of School Health because of its expertise in conducting asthma home environmental assessments and providing home remediation services, which is central to the work of the asthma project (3.d.ii). The Agency Coordination Plan was presented to and received a unanimous recommendation from the Stakeholder and Patient Engagement Committee on June 15, 2016. The Stakeholder and Patient Engagement Committee includes representatives from a range of community partners and therefore was the appropriate governance committee to recommend this document. Please see attached for the full Agency Coordination Plan. The relationships with public sector agencies for DY2 Q1 and subsequent quarters moving forward will

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	be detailed in the Public Sector Agency Template.
Finalize workforce communication and engagement plan	
Inclusion of CBOs in PPS Implementation.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.2 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment narrative	chengc2		52_DY2Q1_GOV_MDL22_PPS1049_OTH_3a_Mid-Point_Assessment_Organizational_Narrative_Template_vf1_5681.pdf	OneCity Health Mid-Point Assessment - Organizational Section narrative	08/05/2016 01:44 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

Please describe the key challenges or risks that you foresee in implementing your governance structure and processes and achieving the milestones described above, as well as potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk: Development and negotiation of the Base Agreement among the partners will likely present challenges, given variability in partner type, size, interests, capabilities and limitations.
Mitigation: We intend to mitigate this risk through the review process we have established. The planned review of the Base Agreement with partners' legal counsel will be transparent and will aim to reach mutually agreeable terms among all partners.

Risk: In addition, time constraints and other day-to-day obligations of governance committee members will pose a risk to the level of meaningful and productive engagement required to ensure a strong and effective governance structure.
Mitigation: This risk will be mitigated by support from the PPS Central Services Organization (CSO) in preparing meeting materials, establishing clear expectations among committee members around advanced meeting preparation, attendance, and active committee involvement. OneCity Health recognizes that committee members have significant obligations to their organizations outside of the PPS and will aim to be respectful of their time commitments.

Risk: As a City-wide PPS, we share partners with several other PPSs. For partners affiliated with multiple PPSs, ensuring that Governance and reporting processes do not present undue burden on these partners will pose a challenge.
Mitigation: We will address this risk by actively coordinating with other PPSs and aligning reporting processes and requests where possible.

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions :

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

The ability to develop the project schedules that are part of the partnership agreements with CBOs will depend on the development of Clinical Operational Plans which will detail partner obligations for each DSRIP project. Creation of the budgets for each partner's involvement in a particular project is dependent upon outputs of the Finance workstream, which will include projected PPS revenue, project budgets, and funds flow projections. In addition, the establishment of robust Performance Reporting/Management systems and capabilities will be critical to effectively monitoring partner performance against agreed-upon targets; these will in turn depend on the successful implementation of Reporting and Analytics IT infrastructure.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.5 - Roles and Responsibilities

Instructions :

Please list and elaborate upon the key people/organizations responsible for the development of your governance structure and processes and describe what their responsibilities involve.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
PPS Governance Leadership	OneCity Health PPS Executive Committee: Ross Wilson, MD, Chair	Review and approve Governance Charters, Clinical Guidelines, Base Agreement and Project Schedules and budgets. Develop contracting priority order.
Lead Applicant/Entity	HHC	Review and approve Governance Charters.
Legal review	Lead Partner (HHC) Legal: Salvatore Russo, Esq, Senior Vice President and General Counsel, HHC	Review Governance Charters and Base Agreement.
Compliance	HHC Chief Compliance Officer: Wayne McNulty	Review PPS compliance plan.
PPS Clinical Governance Leadership	Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Review and recommend clinical guidelines and provide quality oversight.
PPS Clinical Leadership	PPS Chief Clinical Officer: Anna Flattau, MD	Provide quality oversight.
Support infrastructure	PPS Central Services Organization- OneCity Health Services: Christina Jenkins, MD, CEO; Anna Flattau, MD, Chief Clinical Officer; Hub Executive Directors: Nicole Jordan-Martin (Brooklyn), Richard Bernstock (Bronx), Ishmael Carter (Queens), Manattan Hub Executive Director TBD; Hub Program Managers: Caroline Cross (Manhattan); Rachael Steimnitz (Brooklyn); Erfan Karim (Queens); Lindsay Donald (Bronx)	Support development of clinical guidelines, reporting process, partner oversight process, and policies and procedures.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Module 2.6 - IPQR Module 2.6 - Key Stakeholders

Instructions :

Please identify the key stakeholders involved, both within and outside the PPS with regard to your governance structure and processes.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Providers	PPS Partners	Committee membership, including the Project Advisory Committee
Community Based Organizations (CBOs)	PPS Partners	Committee membership, including the Project Advisory Committee
Labor Unions	PPS Partners	Committee membership, including the Project Advisory Committee
Government agencies	PPS Partners	Committee membership, including the Project Advisory Committee
External Stakeholders		
Other PPSs	Cross-PPS Coordination Partners	Coordination on City-wide Reporting standards
NYS Dept of Health	Government agency stakeholder	Coordination on City-wide Reporting standards
NYC Department of Education	Government agency stakeholder	Coordination on Community and Stakeholder Engagement Strategy
City University of New York (CUNY)	Educational institution stakeholder	Coordination on Community and Stakeholder Engagement Strategy
State University of New York (SUNY)	Educational institution stakeholder	Coordination on Community and Stakeholder Engagement Strategy

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.7 - IT Expectations

Instructions :

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream and your ability to achieve the milestones described above.

Timely, accurate, and comprehensive quality and performance reporting will be critical to inform effective and transparent governance processes and decision-making. Shared IT infrastructure enabled by cross-PPS connectivity is required to produce the underlying data for a PPS-wide performance management and reporting process. Given the City-wide scope of the OneCity Health PPS, this connectivity is dependent on enabling successful connectivity between our partners with multiple RHIOs across all boroughs, and among the RHIOs themselves.

Developing the electronic governance portal will enable all PPS partners to access relevant governance materials which will improve engagement in PPS activities.

IPQR Module 2.8 - Progress Reporting

Instructions :

Please describe how you will measure the success of this organizational workstream.

We define success as the achievement of robust, effective, and transparent PPS governance at both a City-wide and Hub level. Fulfillment of the milestones described above will reflect our progress in building the infrastructure required to support this multi-tiered governance. Success will be measured by (1) the occurrence of meetings of the Executive Committee and Subcommittees at a frequency in accordance with the applicable charter, (2) implementation of PPS policies and procedures, (3) execution of the Base Agreement and project schedules by HHC and partners (including CBOs), and (4) performance by OneCity Health and partners (including CBOs) of obligations against the Base Agreement.

IPQR Module 2.9 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1: Finalize appointment of Business Operations & Information Technology Subcommittee membership.	Completed	Step 1: Finalize appointment of Business Operations & Information Technology Subcommittee membership.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Obtain Executive Committee sign off of PPS finance structure, policies and procedures.	Completed	Step 2: Obtain Executive Committee sign off of PPS finance structure, policies and procedures.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Identify and implement required PPS financial controls.	Completed	Step 3: Identify and implement required PPS financial controls.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4: Convene regular Business Operations & Information Technology Subcommittee meetings.	Completed	Step 4: Convene regular Business Operations & Information Technology Subcommittee meetings.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5: Document Business Operations & Information Technology Subcommittee actions and minutes and provide regular reports to PPS Executive Committee.	Completed	Step 5: Document Business Operations & Information Technology Subcommittee actions and minutes and provide regular reports to PPS Executive Committee.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Completed	This milestone must be completed by 3/31/2016. Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers;	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		-- define their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers							
Task Step 1: Assess financial impact resulting from implementation of DSRIP projects, including expected impact on provider cost, patient volumes, revenue, ALOS, and other metrics based upon project goals and provider participation.	Completed	Step 1: Assess financial impact resulting from implementation of DSRIP projects, including expected impact on provider cost, patient volumes, revenue, ALOS, and other metrics based upon project goals and provider participation.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Conduct financial health current state assessment of new PPS partners by utilizing assessment tool developed during the DSRIP planning phase.	Completed	Step 2: Conduct financial health current state assessment of new PPS partners by utilizing assessment tool developed during the DSRIP planning phase.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3: Review and obtain approval of DSRIP impact analysis from Business Operations & Information Technology Subcommittee and PPS Executive Committee as basis for Sustainability and applicable portions of the PPS Flow of Funds plan.	Completed	Step 3: Review and obtain approval of DSRIP impact analysis from Business Operations & Information Technology Subcommittee and PPS Executive Committee as basis for Sustainability and applicable portions of the PPS Flow of Funds plan.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Review all results of financial health current state assessment and, if applicable, identify financially fragile partners.	Completed	Step 4: Review all results of financial health current state assessment and, if applicable, identify financially fragile partners.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Develop process for monitoring financially fragile partners including the involvement of the Business Operations & Information Technology Subcommittee.	Completed	Step 5: Develop process for monitoring financially fragile partners including the involvement of the Business Operations & Information Technology Subcommittee.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6: Review and revise financial health	Completed	Step 6: Review and revise financial health current state assessment tool as needed to capture key financial health,	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
current state assessment tool as needed to capture key financial health, sustainability indicators, and financial impact of DSRIP projects, conduct assessments on an annual basis.		sustainability indicators, and financial impact of DSRIP projects, conduct assessments on an annual basis.							
Task Step 7: Develop Financial Stability Plan – including metrics and ongoing monitoring – and obtain approval from Business Operations & Information Technology Subcommittee.	Completed	Step 7: Develop Financial Stability Plan – including metrics and ongoing monitoring – and obtain approval from Business Operations & Information Technology Subcommittee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1: Onboard Senior Executive Compliance Officer to provide executive compliance oversight and management of DSRIP-related compliance activities and DSRIP Senior Compliance Officer to focus on DSRIP compliance and privacy-related activities.	Completed	Step 1: Onboard Senior Executive Compliance Officer to provide executive compliance oversight and management of DSRIP-related compliance activities and DSRIP Senior Compliance Officer to focus on DSRIP compliance and privacy-related activities.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Operationalize audit committee structure at HHC and PPS levels.	Completed	Step 2: Operationalize audit committee structure at HHC and PPS levels.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3: Conduct DSRIP compliance risk assessment and identification as part of HHC corporate-wide assessment of threats, risks, vulnerabilities, and effectiveness of internal controls in an effort to carry out risk identification requirements under 18 NYCRR part 521 and to score, prioritize, evaluate, mitigate, and monitor corporate-wide risks.	Completed	Step 3: Conduct DSRIP compliance risk assessment and identification as part of HHC corporate-wide assessment of threats, risks, vulnerabilities, and effectiveness of internal controls in an effort to carry out risk identification requirements under 18 NYCRR part 521 and to score, prioritize, evaluate, mitigate, and monitor corporate-wide risks.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4: Create DSRIP Compliance Plan to reflect regulatory compliance expectations related to the use and distribution of DSRIP funds, standards of conduct, receipt of complaints/non-retaliation	Completed	Step 4: Create DSRIP Compliance Plan to reflect regulatory compliance expectations related to the use and distribution of DSRIP funds, standards of conduct, receipt of complaints/non-retaliation policies, monitoring procedures,	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
policies, monitoring procedures, and education/training on DSRIP-related compliance expectations.		and education/training on DSRIP-related compliance expectations.							
Task Step 5: Present PPS Compliance plan to Executive Committee for approval; publish Plan and distribute to PPS partners.	Completed	Step 5: Present PPS Compliance plan to Executive Committee for approval; publish Plan and distribute to PPS partners.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 09/30/2016. Value-based payment plan, signed off by PPS board.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	YES
Task Step 1: Review final State Medicaid value-based payment roadmap upon release.	Completed	Step 1: Review final State Medicaid value-based payment roadmap upon release.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Adapt existing HHC Medicaid value-based payment reporting structure and capture partner value-based data.	In Progress	Step 2: Adapt existing HHC Medicaid value-based payment reporting structure and capture partner value-based data.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3: Assess the current state of Medicaid value-based payment arrangements and associated revenue across all PPS partners. (To be completed/updated on an annual basis.)	In Progress	Step 3: Assess the current state of Medicaid value-based payment arrangements and associated revenue across all PPS partners. (To be completed/updated on an annual basis.)	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4: Develop preferred compensation and Medicaid MCO strategy framework through PPS sub-committees.	In Progress	Step 4: Develop preferred compensation and Medicaid MCO strategy framework through PPS sub-committees.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5: Present assessment to PPS Business Operations and IT Subcommittee and to PPS Executive Committee for review and approval.	In Progress	Step 5: Present assessment to PPS Business Operations and IT Subcommittee and to PPS Executive Committee for review and approval.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	In Progress	This milestone must be completed by 3/31/2017. Value-based payment plan, signed off by PPS board.	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4	YES
Task	Completed	Step 1: Review final State Medicaid value-based payment	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 1: Review final State Medicaid value-based payment roadmap upon release.		roadmap upon release.							
Task Step 2: Review baseline assessment of PPS partners' Medicaid value-based payment revenue to inform development of PPS value-based payment plan.	In Progress	Step 2: Review baseline assessment of PPS partners' Medicaid value-based payment revenue to inform development of PPS value-based payment plan.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 3: Conduct gap assessment between current volume of Medicaid value-based revenue across the PPS network and State target of 90%.	In Progress	Step 3: Conduct gap assessment between current volume of Medicaid value-based revenue across the PPS network and State target of 90%.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 4: Establish annual targets for volume of Medicaid value-based revenue across the PPS network. (To be completed on an ongoing basis.)	In Progress	Step 4: Establish annual targets for volume of Medicaid value-based revenue across the PPS network. (To be completed on an ongoing basis.)	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 5: Finalize PPS Medicaid value-based payment plan and present to Executive Committee for approval. Provide quarterly updates to Executive Committee on progress toward value-based payment and revise PPS plan as needed.	In Progress	Step 5: Finalize PPS Medicaid value-based payment plan and present to Executive Committee for approval. Provide quarterly updates to Executive Committee on progress toward value-based payment and revise PPS plan as needed.	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description
Finalize PPS finance structure, including reporting structure	If there have been changes, please describe those changes and upload any supporting documentation as necessary.	Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box.

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	No, there are no updates at this time.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	No, there are no updates at this time.
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	No, there are no updates at this time.
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.2 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

Please describe the key challenges or risks that you foresee in implementing these cross-cutting organizational strategies, including potential impacts on specific projects and, crucially, any risks that will undermine your ability to achieve outcome measure targets.

• Risk: Insufficient provider engagement
Mitigation: The PPS must meaningfully engage with PPS partners and communicate a set of PPS partner/provider funding schedules at the outset of DSRIP implementation to ensure that partners and their providers understand the process and project milestones tied to receiving payment from the PPS. In addition, as the PPS begins to engage partners around the Master Services Agreement and clinical operational planning, it will need to be transparent on the budgeting and payment processes, and educate partners on the ties to funds flow and, ultimately, funding schedules.

•Risk: Availability of DSRIP waiver funds and uncertainty around the ability of the PPS to achieve and draw down incentive payments both present risks. The PPS must successfully achieve and report on State-established milestones and metrics to draw down incentive payments and subsequently distribute funds to its partners.
Mitigation: The PPS has and will continue to engage in a thoughtful planning process to ensure it is able to achieve DSRIP milestones and metrics in a timely manner and to the best of its ability and will design the budgeting process with flexibility to allow for scenarios in which the PPS may miss certain targets.

• Risk: Timing of DSRIP waiver funds: Once the PPS has demonstrated successful achievement of reporting and/or performance metrics, incentive payments will not be made for 90-120 days, leaving a potential gap in funding available to support DSRIP projects.
Mitigation: The PPS must actively track payments received and expenditures incurred to minimize the periods of low cash holdings. In addition, judicious usage of the PPS Contingency Fund will help to alleviate periods of potential low cash holdings.

• Risk: Alignment of PPS partners with Medicaid value-based payment models: Although the PPS currently has the majority of its Medicaid Managed Care lives in global risk contracts that reward performance consistent with DSRIP, the continued transition to value-based payment across the PPS will require the engagement with PPS partners and Medicaid managed care organizations (MCOs) to align contracting with value-based payment.
Mitigation: As the PPS lead, HHC expects to leverage its considerable experience in managing value-based payment models and extend value-based payment arrangements to other PPS partners.

IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

Instructions :

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

New York City Health and Hospitals Corporation (PPS ID:52)

• Performance reporting: Identify point-of-contact in each partner organization for finance-related matters (e.g., reporting and policies/procedures); base partner reporting requirements on DSRIP reporting milestones/metrics.

• IT: The PPS IT systems must support population health management to enable partners to improve patient outcomes that will drive the transition to value-based payment with Medicaid MCOs and other payers.

• Practitioner Engagement: The PPS must effectively engage and educate physicians and other providers in the evidence-based protocols and requirements that will drive performance and contracting.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.5 - Roles and Responsibilities

Instructions :

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
PPS Governance Leadership	PPS Executive Committee: Ross Wilson, MD, Chair	Review and approve recommendations from Business Operations and IT Subcommittee
PPS Governance Entity	Business Operations and IT Subcommittee: Chair TBD; staffed by Juan Maluf, OneCity Health Services Senior Director for IT Strategies and Implementation, and OneCity Health Services Finance Director	Review and recommend network financial health current state assessment and value-based payment plan
Compliance Oversight	HHC Office of Corporate Compliance and Chief Compliance Officer: Wayne McNulty	Establish and maintain an effective compliance program as required by, and in accordance with, New York Social Services Law 363-d and its implementing regulations found at 18 NYCRR Part 521
Expense Oversight	PPS Comptroller: Julian John, HHC Corporate Comptroller	Review and manage PPS expenditures
Compliance Lead	Chief Compliance Officer: Wayne McNulty	Provide executive compliance oversight and management of DSRIP-related compliance plan and activities
Audit function	Internal Auditor	Review PPS budget and funds flow
Finance Lead	PPS Finance Director: permanent Director being recruited; interim support from HHC Corporate Finance	Prepare PPS budgets and forecasts
HHC Corporate Finance	Marlene Zurack, HHC Corporate Chief Financial Officer; Laura Free, AVP Managed Care Finance; Krista Olson, AVP Corporate Budget Director; Linda Dehart, AVP Corporate Reimbursement	Support PPS Finance operations, financials sustainability planning, and value-based contracting strategy

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.6 - Key Stakeholders

Instructions :

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
PPS Partners	Performing providers	Responsible for performance on program metrics, participation in clinical project implementation, accountability for use of funds
HHC and other Partner Finance Organizations	Finance support	Collaborate with PPS to participate in network financial health assessment and alignment of PPS network with value-based purchasing models
External Stakeholders		
MetroPlus, HealthFirst	Partner in development of value-based payment arrangements	Collaborate with PPS and providers to develop value-based payment arrangements
Other Managed Care Organizations	Partner in development of value-based payment arrangements	Collaborate with PPS and providers to develop value-based payment arrangements

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.7 - IT Expectations

Instructions :

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

A shared IT infrastructure across the PPS will prove instrumental in allowing the PPS to maintain a real-time assessment of performance across partners, which will be critical to success as PPS partners transition to value-based payment. The PPS is establishing a centralized performance management analytics and reporting environment to store normalized claim, clinical and other patient-level data in HHC's Business Intelligence/Enterprise Data Warehouse based on the IBM Provider Data Model. We expect that the dashboards produced using this system will help drive improved outcomes and allow the PPS to monitor performance against key metrics by benchmarking our providers against standardized NQF quality measures to address gaps in care for chronic diseases.

IPQR Module 3.8 - Progress Reporting

Instructions :

Please describe how you will measure the success of this organizational workstream.

The financial sustainability workstream will be considered successful based on the demonstrated ability to:

•Identify and monitor the PPS partner organizations that are or will become financially fragile during the course of the DSRIP period

•Seamlessly implement and adhere to financial controls and the PPS compliance plan

•Establish and execute the PPS' plans to transition to the targeted volume of Medicaid value-based payment revenues.

IPQR Module 3.9 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 04 – Cultural Competency & Health Literacy

IPQR Module 4.1 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement. Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	Completed	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1: Based on a review of the Community Needs Assessment, claims data, and other data available from our PPS partners, determine priority groups experiencing health disparities and needs for cultural competency and health literacy strategy.	Completed	Step 1: Based on a review of the Community Needs Assessment, claims data, and other data available from our PPS partners, determine priority groups experiencing health disparities and needs for cultural competency and health literacy strategy.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Identify areas of demonstrated PPS strength among HHC facilities and other PPS partners in addressing cultural competency,	Completed	Step 2: Identify areas of demonstrated PPS strength among HHC facilities and other PPS partners in addressing cultural competency, health literacy and health disparities; identify key	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
health literacy and health disparities; identify key gaps as well.		gaps as well.							
Task Step 3: Develop a cultural competency and health literacy strategy document, which includes the following minimum components and takes into consideration unique attributes of each PPS Hub: (1) key factors to improve access to quality primary, behavioral health, and preventive care; (2) plans for two-way communication with the population and community groups through specific community forums; (3) assessments and tools to assist patients with self-management (in concert with PPS clinical planning around patient self-management); and, (4) community-based interventions to reduce health disparities and improve outcomes.	Completed	Step 3: Develop a cultural competency and health literacy strategy document, which includes the following minimum components and takes into consideration unique attributes of each PPS Hub: (1) key factors to improve access to quality primary, behavioral health, and preventive care; (2) plans for two-way communication with the population and community groups through specific community forums; (3) assessments and tools to assist patients with self-management (in concert with PPS clinical planning around patient self-management); and, (4) community-based interventions to reduce health disparities and improve outcomes.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4: Review and consensus-driven recommendation of Strategy document by PPS Care Models Subcommittee and Stakeholder & Patient Engagement Subcommittees.	On Hold	Step 4: Review and consensus-driven recommendation of Strategy document by PPS Care Models Subcommittee and Stakeholder & Patient Engagement Subcommittees.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 5: Strategy document reviewed and approved by Executive Committee.	Completed	Step 5: Strategy document reviewed and approved by Executive Committee.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4: Review and consensus-driven recommendation of Strategy document by PPS Stakeholder & Patient Engagement Subcommittee.	Completed	Step 4: Review and consensus-driven recommendation of Strategy document by PPS Stakeholder & Patient Engagement Subcommittee.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Completed	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		others as appropriate) regarding specific population needs and effective patient engagement approaches							
Task Step 1: Determine approach to developing PPS-wide training strategy, including identifying contractors (as relevant) and developing high-level requirements for training needs, taking into account unique local training needs within each of OneCity Health's hubs.	Completed	Step 1: Determine approach to developing PPS-wide training strategy, including identifying contractors (as relevant) and developing high-level requirements for training needs, taking into account unique local training needs within each of OneCity Health's hubs.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: In the context of overall DSRIP-related training, develop specific requirements for training plan for clinicians, focused on available evidence-based research addressing health disparities for groups identified in the OneCity Health cultural competency strategy.	Completed	Step 2: In the context of overall DSRIP-related training, develop specific requirements for training plan for clinicians, focused on available evidence-based research addressing health disparities for groups identified in the OneCity Health cultural competency strategy.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: In the context of overall DSRIP-related training, develop specific requirements for training plans for other segments of the workforce regarding specific population needs and effective patient engagement approaches.	Completed	Step 3: In the context of overall DSRIP-related training, develop specific requirements for training plans for other segments of the workforce regarding specific population needs and effective patient engagement approaches.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Finalize approach to implementing cultural competency training, including contracting (as applicable).	Completed	Step 4: Finalize approach to implementing cultural competency training, including contracting (as applicable).	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: OneCity Health Executive Committee reviews and approves cultural competency training strategy document.	Completed	Step 5: OneCity Health Executive Committee reviews and approves cultural competency training strategy document.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

NYS Confidentiality – High

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize cultural competency / health literacy strategy.	wy622871	Templates	52_DY2Q1_CCHL_MDL41_PRES1_TEMPL_Meeting_Schedule_Template_DY2Q1_5472.xlsx	DY2 Q1 Meeting Schedule Template - CCHL Milestone 1	08/04/2016 04:50 PM
	wy622871	Templates	52_DY2Q1_CCHL_MDL41_PRES1_TEMPL_D2Q1_Training_Materials_Template_5349.xlsx	DY2 Q 1 Training Materials Template - CCHL Milestone 1	08/04/2016 12:27 PM
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	wy622871	Meeting Materials	52_DY2Q1_CCHL_MDL41_PRES2_MM_RE__Reminder__Seeking_OneCity_Health_Executive_Committee_approval_for_two_(2)_recommendations_by_3pm_on_7_29_16_5979.pdf	Executive Committee Approval	09/20/2016 02:29 PM
	wy622871	Meeting Materials	52_DY2Q1_CCHL_MDL41_PRES2_MM_20160721_Stakeholder_&_Patient_Engagement_Committee_Agenda_5978.pdf	Stakeholder's Committee Agenda	09/20/2016 02:29 PM
	wy622871	Meeting Materials	52_DY2Q1_CCHL_MDL41_PRES2_MM_CCHL_Pages_from_20160721_Stakeholders_Committee_Meeting_Materials_vf_5976.pdf	Stakeholders Committee Meeting Materials	09/20/2016 02:27 PM
	wy622871	Meeting Materials	52_DY2Q1_CCHL_MDL41_PRES2_MM_20160721_OneCity_Health_Stakeholder_and_Patient_Engagement_Committee_MeetingMinutes_vf_5975.pdf	Stakeholder and Patient Engagement Committee Meeting Minutes	09/20/2016 02:26 PM
	chengc2	Templates	52_DY2Q1_CCHL_MDL41_PRES2_TEMPL_Training_Schedule_Template_DY2Q1_5624.xlsx	OneCity Health PPS Training Schedule Template	08/05/2016 11:35 AM
	wy622871	Other	52_DY2Q1_CCHL_MDL41_PRES2_OTH_OneCity_Health_PPS_CCHL_Training_Strategy_5572.pdf	OneCity Health PPS Cultural Competency and Health Literacy Training Strategy	08/05/2016 06:41 AM
	wy622871	Other	52_DY2Q1_CCHL_MDL41_PRES2_OTH_APPENDIX_1__Patient_Priority_Zip_Code_Analysis_CCHL_Strategy_5358.pdf	Appendix to OneCity Health PPS CCHL Training Strategy	08/04/2016 12:39 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	No, there are no updates at this time.
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	The OneCity Health Cultural Competency and Health Literacy (CCHL) training strategy outlines the PPS-wide approach to identify and support populations experiencing disparities through CCHL organizational assessment process improvements, workforce training development, and patient engagement/education efforts. The training strategy addresses five aims to increase provider acceptance and optimize training impact: 1) high accessibility, 2) optimize time/length of training for effectiveness, 3) collaboration and leveraging existing partner resources, 4) utilizing evidence-based training methods, and 5) relevant and sustainable training outcomes. Upon execution, the PPS-wide training strategy provides guidance to the workforce who will support consumers seeking health and social services within the

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	OneCity Health network. The PPS anticipates that the following job categories will be impacted most by the CCHL training strategy: primary care providers, subspecialty providers, nurses, pharmacists, psychiatrists and psychologists, social workers (including licensed clinical social workers), healthcare navigators, care coordinators, community health workers and care managers, population health management experts, home health professionals and paraprofessionals. The training strategy builds on existing efforts from partners that are already engaging the identified priority populations and offering CCHL training to the provider roles listed above. The CCHL training strategy is informed by, and will be integrated with, multiple other strategies developed in parallel including the OneCity Health Practitioner Communication and Engagement Plan and OneCity Health Practitioner Training and Education Plan as well as the PPS's overall approach to other transformational efforts including IT, clinical projects, care management, communication strategy, patient engagement, and community-based organization engagement. The OneCity Health training team, which includes staff from the 1199SEIU Training and Employment Funds, oversees the development and execution of the CCHL training strategy. The CCHL training strategy was recommended by both the Stakeholder and Patient Engagement Committee and Workforce Committee (a subcommittee to the Stakeholder and Patient Engagement Committee) and approved by the Executive Committee. Please see the attached OneCity Health Cultural Competency and Health Literacy (CCHL) training strategy and the Training Schedule Template for more details. ++++ 9/20/16 Update The OneCity Health Cultural Competency/Health Literacy Training Strategy was reviewed and recommended by the Stakeholder & Patient Engagement Committee for Executive Committee approval on July 21, 2016. The Executive Committee approved the strategy on July 29, 2016. Attached, please find 1) Stakeholder & Patient Engagement Committee meeting minutes and materials, and 2) an e-mail to the Executive Committee that demonstrates the approval. Portions directly applicable to CCHL Milestone 2 are highlighted for your convenience.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.2 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

Please describe the key challenges or risks that you foresee in implementing your cultural competency / health literacy strategy and addressing the specific health disparities you are targeting (based on your CNA), and achieving the milestones described above - including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk: We have identified a number of risks to implementation. First, the degree of cultural, ethnic and language diversity across our service area will challenge our PPS to meet the needs of all attributed patients. For example, the population of foreign born residents with low literacy rates ranges from 24.6% to 48% [being validated]. This will make prioritization of resources and training approaches more complex and resource intensive.
Mitigation: To mitigate this risk, we intend to work with partners with demonstrated expertise in meeting the needs of their respective communities. This work will include leveraging existing best practices to identify and meet the education and training needs across the PPS.

Risk: The second risk we have identified is the time needed to provide cultural competency and health literacy training to clinicians and staff. In addition to training on these topics, we expect to have a broad range of DSRIP-related training and educational needs, including needs around clinical guidelines and processes, operational workflows, PPS standards, data collection and monitoring, etc.
Mitigation: To address this risk, we intend to design and deploy a training strategy that identifies all the clinical and non-clinical training needs and includes a rational approach to delivering that training. As a result of the need to harmonize PPS-wide training efforts, cultural competency and health literacy training may be on a slightly less aggressive timeframe than it would otherwise be.

Risk: Finally, the City-wide scope of the OneCity Health PPS introduces a high degree of complexity and diversity in executing on an effective Cultural Competency/Health Literacy strategy, as patient and community needs/engagement will vary across boroughs and geographies.
Mitigation: OneCity Health's Hub-based structure will allow for this risk to be mitigated through Hub-based planning that takes into account the local network of established community-based organizations and local knowledge/expertise around patient engagement barriers and solutions.

IPQR Module 4.4 - Major Dependencies on Organizational Workstreams

Instructions :

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

As described in Risks & Mitigation Strategies, the achievement of OneCity Health's cultural competency and health literacy strategies is dependent on developing the overall approach to PPS training and education and an overarching Practitioner Engagement strategy. In addition, because the strategy relies on a keen understanding of existing areas of expertise and available tools among partners, we must first complete a partner assessment process, which seeks to identify partner capabilities and capacity across a broad range of areas, including cultural competency. Finally, the ability of providers to meet the language needs of their patients will be dependent on the capability to know a patient's preferred language. As a result, OneCity Health will need systems to track and share this information with partners in the PPS.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.5 - Roles and Responsibilities

Instructions :

Please list and elaborate upon the key people/organizations responsible for this workstream and describe what their responsibilities involve.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Supporting the PPS governance Committees and Partners	OneCity Health Services: Christina Jenkins, MD, CEO	Working with PPS governance committees and partners to ensure the PPS meets DSRIP milestones.
Governance	Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Review and recommend clinical processes for project implementation, including cultural competency/health literacy standards.
Governance	Patient & Stakeholder Engagement Subcommittee	Review and recommend strategy to engage patients and stakeholders, including cultural competency/health literacy standards.
Governance	OneCity Health Executive Committee: Ross Wilson, MD, Chair	Review recommendations from subcommittees.
PPS Cultural Competency Lead	Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Accountable for the development of cultural competency/health literacy standards

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.6 - Key Stakeholders

Instructions :

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Project Advisory Committees	Total PPS and Hub-based PACs	Provide input and feedback into PPS cultural competency/health literacy initiatives
Providers	PPS Partners	Provide input and feedback into PPS cultural competency/health literacy initiatives
Community Based Organizations (CBOs)	PPS Partners	Provide input and feedback into PPS cultural competency/health literacy initiatives
Labor Unions	PPS Partners	Provide input and feedback into PPS cultural competency/health literacy training plans
External Stakeholders		
Other PPSs	Cross-PPS Coordination Partners	Coordination on City-wide CC/HL approaches
NYS Dept of Health	Government agency stakeholder	Coordination on City-wide CC/HL approaches

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.7 - IT Expectations

Instructions :

Please clearly describe how the development of shared IT infrastructure across the PPS will support the development and implementation of your cultural competency / health literacy strategy and the achievement of the milestones described above.

As described in Major Dependencies on Other Workstreams, there are a number of areas where IT capabilities will enable OneCity Health to address cultural competency and health literacy issues. First, providers will need to meet the language needs of their patients. This may include access to interpreter services, providing educational materials that have been translated into another language, or connecting patients to a support group that meets a patient's cultural and ethnic preferences. To respond to these requirements, OneCity Health will need to identify and track the language preferences of its attributed patients and ensure this information is accessible to PPS clinicians and staff at the point of care. OneCity Health will also need to determine threshold languages for translation needs and make translated materials available across the PPS. Finally, OneCity Health will need to track and make available PPS resources (e.g., in-language support groups) so that patients can be easily connected to community supports that improve self-management and self-efficacy efforts.

In addition, the tools and approaches adopted by the PPS to engage patients in self-management and to promote self-efficacy will need to be tailored to the culturally-specific strategies unique to each community. Flexible IT platforms to house and deploy these tools will be critical to ensuring that patient engagement strategies are responsive to these local needs.

Finally, technology support will be required for tracking of training program delivery and effectiveness.

IPQR Module 4.8 - Progress Reporting

Instructions :

Please describe how you will measure the success of this organizational workstream.

We define successful design and deployment of a PPS Cultural Competency/Health Literacy strategy as the effective incorporation of the unique cultural and health literacy needs and barriers of our patient populations into the process by which our clinical guidelines, operational processes, and training programs are developed and implemented. Fulfillment of the milestones for this workstream will reflect our progress in building the infrastructure required to support this strategy. Success will be measured by the degree to which key health disparity and patient engagement activation are improved across the PPS.

IPQR Module 4.9 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	Completed	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1: Central Services Organization to organize, review and assess partner IT readiness assessment data collected via the Partner Readiness Assessment Tool, populate interim partner database, and conduct further data collection via interviews or site visits to fill gaps.	Completed	Step 1: Central Services Organization to organize, review and assess partner IT readiness assessment data collected via the Partner Readiness Assessment Tool, populate interim partner database, and conduct further data collection via interviews or site visits to fill gaps.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Review partner data to assess current state of data sharing readiness in terms of Meaningful Use Certified EHRs and connectivity to the QEs (HIE). Vet key results with select partners and PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Completed	Step 2: Review partner data to assess current state of data sharing readiness in terms of Meaningful Use Certified EHRs and connectivity to the QEs (HIE). Vet key results with select partners and PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Complete IT current state assessment supporting documentation for central PPS and partner IT.	Completed	Step 3: Complete IT current state assessment supporting documentation for central PPS and partner IT.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop an IT Change Management Strategy.	In Progress	IT change management strategy, signed off by PPS Board. The strategy should include:	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		-- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes							
Task Step 1: Establish Business Operations & Information Technology Subcommittee, which includes representation across Partners.	Completed	Step 1: Establish Business Operations & Information Technology Subcommittee, which includes representation across Partners.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2: Document Business Operations & Information Technology Subcommittee charter and processes.	Completed	Step 2: Document Business Operations & Information Technology Subcommittee charter and processes.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Develop communication, education and training plan related to IT Change Management.	In Progress	Step 3: Develop communication, education and training plan related to IT Change Management.	01/01/2016	06/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4: Develop impact/risk assessment for IT change process.	In Progress	Step 4: Develop impact/risk assessment for IT change process.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5: Define workflows for authorizing and implementing IT changes.	In Progress	Step 5: Define workflows for authorizing and implementing IT changes.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	In Progress	Roadmap document, including current state assessment and workplan to achieve effective clinical data sharing and interoperable systems where required. The roadmap should include: -- A governance framework with overarching rules of the road for interoperability and clinical data sharing; -- A training plan to support the successful implementation of new platforms and processes; and -- Technical standards and implementation guidance for sharing and using a common clinical data set -- Detailed plans for establishing data exchange agreements between all providers within the PPS, including care management records (completed subcontractor DEAAs with	10/01/2015	06/30/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).							
Task Step 1: Document clinical connectivity roadmap (QEs) and PPS partner strategy for exchanging clinical data set and obtain Business Operations & Information Technology Subcommittee approval.	Completed	Step 1: Document clinical connectivity roadmap (QEs) and PPS partner strategy for exchanging clinical data set and obtain Business Operations & Information Technology Subcommittee approval.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.	Completed	Step 2: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Establish and communicate connectivity priorities, and partner support resources, including training plan and/or third party assistance programs.	In Progress	Step 3: Establish and communicate connectivity priorities, and partner support resources, including training plan and/or third party assistance programs.	10/01/2015	06/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4: Develop approach for tracking and reporting on changes to data sharing agreements.	In Progress	Step 4: Develop approach for tracking and reporting on changes to data sharing agreements.	10/01/2015	06/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Completed	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1: Validate/match attributed members against QE RHIO consents on file to inform engagement strategy/plan.	Completed	Step 1: Validate/match attributed members against QE RHIO consents on file to inform engagement strategy/plan.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Review current consent processes and lessons learned/challenges with QE.	Completed	Step 2: Review current consent processes and lessons learned/challenges with QE.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3: Develop recommendations for outreach to members to obtain consent and obtain Business Operations & Information Technology Subcommittee and Executive Committee	Completed	Step 3: Develop recommendations for outreach to members to obtain consent and obtain Business Operations & Information Technology Subcommittee and Executive Committee approval, leveraging broader patient engagement strategy and emerging cultural competency strategy.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
approval, leveraging broader patient engagement strategy and emerging cultural competency strategy.									
Task Step 4: Develop approach for tracking and reporting on member engagement in QE.	Completed	Step 4: Develop approach for tracking and reporting on member engagement in QE.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Develop a data security and confidentiality plan.	Completed	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled out throughout network.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Analyze data security risks and design controls and strategy to mitigate risks.	Completed	Step 1: Analyze data security risks and design controls and strategy to mitigate risks.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Develop plan for ongoing security testing.	Completed	Step 2: Develop plan for ongoing security testing.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3: Incorporate risk mitigation and security testing recommendations into data security and confidentiality plan and obtain Business Operations & Information Technology Subcommittee and Executive Committee approval.	On Hold	Step 3: Incorporate risk mitigation and security testing recommendations into data security and confidentiality plan and obtain Business Operations & Information Technology Subcommittee and Executive Committee approval.	10/01/2015	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 4: Develop approach for tracking and reporting on implementation of plan.	On Hold	Step 4: Develop approach for tracking and reporting on implementation of plan.	10/01/2015	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

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New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	jwarrick	Templates	52_DY2Q1_IT_MDL51_PRES1_TEMPL_OneCity_Health_Business_Operations_and_IT_Committee_Meeting_DY2Q1_5284.xlsx	OneCity Health Business Operations & IT Committee Meeting Schedule DY2Q1	08/04/2016 09:53 AM
Develop a data security and confidentiality plan.	wy622871	Other	52_DY2Q1_IT_MDL51_PRES5_OTH_OHIP_DOS_Control_Scorecard_-_DY2Q1_Notes_-_NYC_Health_(HHC)_9-20-2016_Update_5985.xlsx	OHIP_DOS_Control_Scorecard_-_DY2Q1_Notes_-_NYC_Health_(HHC)_9-20-2016_Update	09/23/2016 09:42 AM
	wy622871	Other	52_DY2Q1_IT_MDL51_PRES5_OTH_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(SA_Family)_9-20-2016_5984.docx	(SSP) Moderate Plus Workbook (SA Family) 9-20-2016.docx	09/23/2016 09:41 AM
	wy622871	Other	52_DY2Q1_IT_MDL51_PRES5_OTH_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PM_Family)_9-20-2016_5983.docx	(SSP) Moderate Plus Workbook (PM Family) 9-20-2016.docx	09/23/2016 09:40 AM
	wy622871	Other	52_DY2Q1_IT_MDL51_PRES5_OTH_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PL_Family)_9-20-2016_5982.docx	(SSP) Moderate Plus Workbook (PL Family) 9-20-2016.docx	09/23/2016 09:39 AM
	wy622871	Other	52_DY2Q1_IT_MDL51_PRES5_OTH_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(MA_Family)_09-20-2016_5981.docx	(SSP) Moderate Plus Workbook (MA Family) 09-20-2016.docx	09/23/2016 09:39 AM
	wy622871	Other	52_DY2Q1_IT_MDL51_PRES5_OTH_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(CP_Family)_09-20-2016_5980.docx	(SSP) Moderate Plus Workbook (CP Family) 09-20-2016.docx	09/23/2016 09:38 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	• No, there are no updates at this time with the IT assessment document. • The meeting schedule of the IT governance body for the quarter is attached.
Develop an IT Change Management Strategy.	The delayed announcement and distribution of the Capital Restructuring Financing Program (CRFP) award has deferred OneCity Health's timeline in developing a communication, education and training plan related to IT Change Management. In response, the end date of step 3 of milestone 2 is being moved to DY2 Q2. Through the Business Operations and IT Committee, OneCity Health has engaged partners and informed them of key developments within the PPS and guidance regarding technological initiatives from the New York State Department of Health (NYS DOH). The delivery of the CRFP award has enabled OneCity

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New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Health to actively proceed with planning across the PPS, utilizing assessments collected from PPS partners and the data sets from NYS DOH.
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	The delayed announcement and distribution of the Capital Restructuring Financing Program (CRFP) award, particularly in funding messaging (HL7) and connectivity (HISP) for partners, and the lack of clarity regarding the functionality of Qualified Entities (QEs) has delayed the timeline for developing of a roadmap to achieving clinical data sharing and interoperable systems across PPS network. In response, the end date for milestone 3 is changed to DY2 Q3 and the end date for steps 3 and 4 are changed to DY2 Q2. The delivery of the CRFP award has allowed the PPS to create a more complete roadmap. OneCity Health has been actively working towards achieving clinical data sharing and an interoperable system. OneCity Health conducted a PPS-wide assessment to evaluate present IT functionality, which will inform the current state needs and priorities of the roadmap. In addition, to facilitate communication between providers, OneCity Health is using messaging through GSI, a centralized care coordination platform to facilitate communication between providers. OneCity Health is also working to create a unified QE consent to enable clinical data sharing across the PPS.
Develop a specific plan for engaging attributed members in Qualifying Entities	• No, there are no updates at this time for the plan for engaging attributed members in Qualifying Entities. • Updated contact information for the person responsible for developing and monitoring the plan: Gerardo Escalera, Interim Senior Director IT Strategy and Implementation, e-mail Gerardo.Escalera@nychhc.org, tel. 646-694-7048.
Develop a data security and confidentiality plan.	As per the guidance from NYS DOH, please refer to the attached security workbooks in support of this milestone. Note: Milestone 5 steps 3 and 4 are put on hold based on 6/20 communication from the IA: "Sufficient completion of the SSP Workbooks is all that is required of PPS' for IT Systems and Processes Milestone 5. The other submission requirements as detailed by the validation protocols are no longer necessary." +++ 9/22/16 Per IA and DOH instructions, DY2 Q1 remediation was completed on the following notebooks and re-uploaded: SSP Moderate Plus Workbooks: CP, MA, PL, PM, and SA families Additional details are included in the OHIP DOS Control Scorecard DY2 Q1 notes spreadsheet.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 5.2 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

Please describe the key challenges or risks that you foresee in creating and implementing your IT governance structure, your plans for data sharing across your network, your approach to data security and confidentiality, and the achievement of the milestones described above, including the potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk: We anticipate reluctance on the part of some partners to agree to certain elements of IT governance and requirements, since it will require them to use IT systems and processes unfamiliar to them, some of which may duplicate systems and processes already in place within their own organizations.
Mitigation: We will educate partners on the need and justification for all requirements, processes and IT change management governance and incorporate provisions for complying with them into contractual agreements to eliminate ambiguity and clarify that compliance is contractually obligated.

Risk: Partners may be challenged—financially or otherwise— to comply with data sharing obligations, especially those who had not previously participated in data exchange or whose IT infrastructures may not meet certified EHR MU requirements.
Mitigation: Again, we will educate all partners on the importance of data sharing and incorporate data sharing agreements into their contracts.

Risk: Patient engagement in QEs, as measured by consent, is critical to achieving patient engagement speed and scale for 2.a.i and many other projects, since consent is required for data sharing and data sharing is integral to meeting the requirements of most projects.
Mitigation: We will work with the Bronx RHIO, Healthix and Interboro QEs to understand gaps in patient engagement, as measured by consent, and to implement targeted strategies for obtaining consent from more attributed patients.

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

Instructions :

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

The IT workstream is dependent on strategies and requirements developed in the Performance Reporting, Clinical Integration and Population Health Management workstreams primarily, and to a lesser extent in all other organizational workstreams to the extent they identify IT expectations (e.g., for a learning management system in the Workforce workstream). In addition, the IT workstream will be highly interdependent with general project implementation for Domain 2 & 3 project-specific strategies and their Domain 1 requirements. Elements of IT governance may be dependent on the Governance workstream since the Business Operations & Information Technology Subcommittee and other elements of IT governance will be integrated into overall OneCity Health governance. Finally, to the extent that meeting connectivity and EHR certification requirements requires financial investment, the PPS is dependent on capital funding requested through the Capital Restructuring Financing Program.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 5.5 - Roles and Responsibilities

Instructions :

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
IT Management and Support	HHC Enterprise IT Services (EITS)	Complete Integrated OneCity Health IT strategy. Manage QE relationships, and HHC/QE integration/interfaces. Manage overall IT implementation Strategy (central and partner connectivity).
Partner IT Liaisons	TBD – 1 per partner	Connectivity adoption, implementation, integration and support at own organization (for participation in OneCity Health). Data exchange support.
Support Infrastructure	OneCity Health Central Services Organization	Partner network relationship management and program management for implementation/ integration support. Project management and coordination.
PPS Governance Leadership	OneCity Health Executive Committee	Approval of certain IT governance decisions.
PPS Governance Entity	OneCity Health Care Models Subcommittee	Advice related to integrated DSRIP IT strategy.
PPS Governance Entity	OneCity Health Business Operations & Information Technology Subcommittee	Approval of certain IT governance decisions and oversight of certain IT processes and expenditures.
PPS Governance Entity	OneCity Health Stakeholder & Patient Engagement Subcommittee	Advice related to patient engagement in certain IT systems and processes.
PPS Governance Entity	OneCity Health Hub Steering Committees	Advice related to local implementation requirements of integrated DSRIP IT strategy.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 5.6 - Key Stakeholders

Instructions :

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Attributed Patients and Families/Caregivers	Recipient of care services delivered with support of effective IT	Interaction sufficient to participate and take limited accountability for health and care-related activities.
OneCity Health CSO Business and IT Staff	Accountable for project management, integration and effective use of IT in PPS services	Oversight and integration of IT into OneCity Health operations Project management.
OneCity Health Governance Committee Members	Governance for effective integration and use of IT, centrally and across partners	Oversight and integration of IT into OneCity Health operations.
HHC Management/Leadership	Fiduciary oversight for effective integration and use of IT in OneCity Health operations	Oversight and integration of IT into OneCity Health and HHC operations.
HHC Enterprise IT Services (EITS) Leadership and Staff	Primary leadership and operational support	Coordinate, support and maintain coordinated OneCity Health (and HHC) IT solutions.
Partner Organization Providers and Staff	Project management, integration, connectivity and effective use of OneCity Health IT solutions	Adopt, implement, use and support integrated OneCity Health IT solutions, depending on role.
External Stakeholders		
QE Management/Leadership and Staff	Accountable for integration of key QE-supplied IT functionality for OneCity Health support	Oversight and integration of QEs into OneCity Health operations.
Community Advocates/Leaders/Elected Officials	Awareness of how IT is being used to effectively support OneCity Health and patients in the community at-large	Consume stakeholder communication and participation in stakeholder events.
Community Members/Public At-Large	Awareness of how IT is being used to effectively support OneCity Health and patients in the community	Consume stakeholder communication and participation in stakeholder events.
Non-Partner Providers	Awareness of how IT is being used to effectively support patients in the community and how they can participate in IT and connectivity-related solutions related to OneCity Health	QE participation as warranted to effectively treat patients.
Medicaid Managed Care Organizations (MCOs)	Awareness of how IT is/can be used to serve covered members	Contribute data and participate in QE and other IT solutions as warranted to effectively serve members.
DOHMH	Awareness of how IT is being used by OneCity Health	Offer solutions, participate in OneCity Health IT solutions in order to serve residents.
NYSDOH	Provide guidance and tools, including MAPP/SIM, to support OneCity Health use of IT	Guidance and tools to support OneCity Health IT use, including for efficient performance management and DOH reporting.
Labor Unions	Awareness of how IT is being used by OneCity Health	Member labor support for and training on OneCity Health IT solutions, as warranted.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Other PPSs	Awareness of how IT is being used to effectively support patients in the community and how multiple PPSs may be able support each other's or share IT solutions	Participation in joint IT planning and solution development as warranted.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 5.7 - Progress Reporting

Instructions :

Please describe how you will measure the success of this organizational workstream.

Successful design and deployment of an IT systems and processes approach will be measured by the Central Services organization along the following dimensions:

• Governance participation – Multi-stakeholder representation and participation in Business Operations & Information Technology Subcommittee meetings;

• Strategy/Solution Development – Timely completion of current state assessment, IT connectivity roadmap, data sharing plan, etc. according to the milestone dates outlined for this workstream;

• QE Adoption and Integration – Percentages of providers using OneCity Health-affiliated QEs and patients consenting to disclosure, tracked using the partner network management database; and

• Meaningful Use tracking – Percentages of required providers meeting MU standards, tracked using the partner network management database.

IPQR Module 5.8 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 06 – Performance Reporting

IPQR Module 6.1 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	In Progress	Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1: Identify and list all clinical pathways related to DSRIP.	On Hold	Step 1: Identify and list all clinical pathways related to DSRIP.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 2: Determine individuals responsible for outcomes of clinical pathways and for financial outcomes.	On Hold	Step 2: Determine individuals responsible for outcomes of clinical pathways and for financial outcomes.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 3: Establish requirements and metrics for clinical quality and performance dashboards.	Completed	Step 3: Establish requirements and metrics for clinical quality and performance dashboards.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: Develop draft performance reporting and communications strategy, including: (1) identification of individuals responsible for clinical and financial outcomes of specific patient populations; (2) plans for the creation and use of clinical quality and performance dashboards; and (3) approach to rapid cycle evaluation.	On Hold	Step 4: Develop draft performance reporting and communications strategy, including: (1) identification of individuals responsible for clinical and financial outcomes of specific patient populations; (2) plans for the creation and use of clinical quality and performance dashboards; and (3) approach to rapid cycle evaluation.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 5: Define the content of and the production	In Progress	Step 5: Define the content of and the production model for clinical, administrative, and financial reports and analyses to	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
model for clinical, administrative, and financial reports and analyses to ensure PPS performance and to meet DSRIP requirements.		ensure PPS performance and to meet DSRIP requirements.							
Task Step 6: Review of draft performance reporting and communications strategy by partners.	In Progress	Step 6: Review of draft performance reporting and communications strategy by partners.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 7: Review and consensus-driven recommendation of draft performance reporting and communications strategy by Care Models and Business Operations & Information Technology Subcommittees.	In Progress	Step 7: Review and consensus-driven recommendation of draft performance reporting and communications strategy by Care Models and Business Operations & Information Technology Subcommittees.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 8: PPS Executive Committee approves performance reporting and communications strategy document.	In Progress	Step 8: PPS Executive Committee approves performance reporting and communications strategy document.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 1: Outline contents of information to be shared as part of PPS performance reporting structure.	Completed	Step 1: Outline contents of information to be shared as part of PPS performance reporting structure.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Determine the appropriate venue for information flow.	Completed	Step 2: Determine the appropriate venue for information flow.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Develop draft performance reporting and communications strategy approach including: (1) policies, procedures and detailed process for reporting and communication on clinical quality and performance reporting; (2) a detailed plan for creation and use of clinical quality and performance dashboards; (3) approaches to detailed rapid cycle evaluation; and (4) details on data security through appropriate data use agreements.	In Progress	Step 4: Develop draft performance reporting and communications strategy approach including: (1) policies, procedures and detailed process for reporting and communication on clinical quality and performance reporting; (2) a detailed plan for creation and use of clinical quality and performance dashboards; (3) approaches to detailed rapid cycle evaluation; and (4) details on data security through appropriate data use agreements.	01/01/2016	06/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	In Progress	Finalized performance reporting training program.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 1: Identify training requirements to meet PPS clinical quality and performance reporting standards.	Completed	Step 1: Identify training requirements to meet PPS clinical quality and performance reporting standards.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2: Conduct baseline current state analysis of existing quality/performance reporting training programs across the PPS, including those conducted by MCOs.	In Progress	Step 2: Conduct baseline current state analysis of existing quality/performance reporting training programs across the PPS, including those conducted by MCOs.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3: Determine IT requirements for training program, such as learning management system.	In Progress	Step 3: Determine IT requirements for training program, such as learning management system.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 4: Leveraging existing best practices and in coordination with other education and training activities, develop plan to establish training program, including requirements for CBO contracts.	In Progress	Step 4: Leveraging existing best practices and in coordination with other education and training activities, develop plan to establish training program, including requirements for CBO contracts.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 5: Establish process to monitor and report on participation in training programs.	In Progress	Step 5: Establish process to monitor and report on participation in training programs.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 6: Identify potential CBOs to carry out training program.	In Progress	Step 6: Identify potential CBOs to carry out training program.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 7: Finalize performance reporting training program and execute contracts as appropriate.	In Progress	Step 7: Finalize performance reporting training program and execute contracts as appropriate.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	OneCity Health has developed policies, procedures, and a process for metric reporting in Demonstration Year 2. A performance management framework was communicated to the PPS network in early July to review project implementation following the release of the Comprehensive Schedules B. Beginning in the DY2 Q2, partners will be able to track and monitor performance through a web-based portal designed to inform and streamline submission. A reporting manual has also been created to provide additional details on reporting requirements, such as formatting and frequency. The end date for step 4 of milestone 1 is delayed until DY2 Q2 for the following reasons: until very recently, the PPS has experienced significant delays in accessing claims data needed to build dashboards with clinical quality and performance data. The PPS expects greater performance reporting capabilities on clinical and quality measures as more data becomes available from the New York State Department of Health (NYS DOH) through the Salient Interactive Miner (SIM) and the DSRIP dashboards. Further development around approaches to rapid cycle evaluation and quality improvement are also expected to take place with the imminent hire of a Senior Director for Quality Improvement. Lastly, lack of specific guidance from the NYS DOH regarding data sharing consent between PPSs has delayed the development around a robust data security plan or sharing to downstream providers.
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 6.2 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

Please describe the key challenges or risks that you foresee in implementing performance reporting structures and processes and effective performance management within your network, including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk: The first risk we have identified is the variability in health IT capabilities and levels of experience in data-driven population health and quality improvement activities. Variation exists around collecting and using clinical and care management data, reporting, and population health management tools to shape care delivery.
Mitigation: We have two mitigation strategies to address this risk. First, we will seek to better understand partner reporting capabilities through our partner readiness assessment process. Second, we will work with partners to provide training on PPS care management tools, interpreting reports, and using these data to improve clinical outcomes.

Risk: We also anticipate a risk associated with effectively defining and communicating performance standards and expectations across the PPS. Because the PPS will evolve as a "learning organization," it will be challenging to set expectations in Demonstration Year 1 as the PPS will mature and standards will change.
Mitigation: To mitigate this risk, we will focus on a robust communications process with partners and adjusting our approach and standards as needed to ensure DSRIP performance and the delivery of high-quality, patient-centered care.

IPQR Module 6.4 - Major Dependencies on Organizational Workstreams

Instructions :

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

This workstream is dependent on workstreams related to workforce and practitioner engagement. Both workstreams include training and education activities, and our PPS seeks to harmonize all DSRIP-related training in order to reduce the burden on providers and staff and ensure a coordinated approach.

The care management and performance reporting workstreams are interdependent in important ways. The care management model that OneCity Health defines will directly affect the types of reports and content of those reports that care managers will use to manage day-to-day tasks and patient interactions. Because of this, care managers will be involved early in the process of defining the technical specifications of reports and will work closely with staff charged with application development.

This workstream is also dependent upon a number of IT components, as described under IT expectations for this workstream. First, identification and implementation of a learning management system, as described throughout this implementation plan, will facilitate education and training related to performance. Second, data sharing will be key to monitoring performance.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 6.5 - Roles and Responsibilities

Instructions :

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
PPS Clinical Leadership	PPS Chief Clinical Officer: Anna Flattau, MD	Spearhead performance measurement selection process; provide quality oversight and input into strategies to address low-performing providers.
PPS Governance Leadership	OneCity Health PPS Executive Committee: Ross Wilson, MD, Chair	Review and approve performance reporting and communications strategy. General DSRIP oversight.
PPS Governance Leadership	Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Review and recommend draft performance reporting and communications strategy.
PPS Governance Leadership	Business Operations & Information Technology Subcommittee: Chair TBD; staffed by Juan Maluf, OneCity Health Services Senior Director for IT Strategies and Implementation, and OneCity Health Services Finance Director	Review and recommend draft performance reporting and communications strategy.
Support Infrastructure	PPS Central Services Organization, OneCity Health Services : Christina Jenkins, MD, CEO; Anna Flattau, MD, Chief Clinical Officer; Hub Executive Directors: Nicole Jordan-Martin (Brooklyn), Richard Bernstock (Bronx), Ishmael Carter (Queens), Manattan Hub Executive Director TBD; Hub Program Managers: Caroline Cross (Manhattan); Rachael Steimnitz (Brooklyn); Erfan Karim (Queens); Lindsay Donald (Bronx)	Support development of a training programs, participant-level data needs, and training outcomes.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 6.6 - Key Stakeholders

Instructions :

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Providers	PPS Partners	Ensure PPS can collect performance data as needed
Community based organizations	PPS Partners	Ensure PPS can collect performance data as needed; support for implementing performance reporting training program as needed
External Stakeholders		
Other PPSs	Cross-PPS Coordination Partners	Coordination on City-wide Performance Reporting approaches
NYS Dept of Health	Government agency stakeholder	Coordination on City-wide Performance Reporting approaches
Consumers	PPS patients and families	Coordination to ensure performance metrics are patient and family centric

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 6.7 - IT Expectations

Instructions :

Please clearly describe how the development of shared IT infrastructure across the PPS will support your approach to performance reporting.

First, identification and implementation of a learning management system, as described throughout this implementation plan, will facilitate education and training related to performance. Second, data sharing will be key to monitoring performance on both clinical and financial metrics and producing dashboards on both. The PPS is establishing a centralized performance management analytics and reporting environment to store normalized claim, clinical and other patient-level data in HHC's Business Intelligence/Enterprise Data Warehouse based on the IBM Provider Data Model. We expect that the dashboards produced using this system will help drive improved quality and performance reporting.

IPQR Module 6.8 - Progress Reporting

Instructions :

Please describe how you will measure the success of this organizational workstream.

We will measure the success of this workstream across three broad dimensions. First, we must develop the two deliverables (performance reporting and communications strategy, performance training program) within the implementation plan timeframe. Second, we must submit PPS-wide metrics, as outlined in Attachment J and the Domain I metrics. Third, we must develop and implement a strategy for the rapid cycle evaluation of our PPS, thus enabling us to identify areas of strength and to target areas for improvement.

IPQR Module 6.9 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	Completed	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Develop draft practitioner communication and engagement plan which leverages the Hub-based PPS structure to identify local practitioner needs, builds on existing professional groups, and addresses: (1) plans for creating PPS-wide professional groups/communities and their role in the PPS structure; (2) development of standard performance reports to professional groups; and (3) identification of profession/peer-group representatives for relevant governing bodies.	Completed	Step 1: Develop draft practitioner communication and engagement plan which leverages the Hub-based PPS structure to identify local practitioner needs, builds on existing professional groups, and addresses: (1) plans for creating PPS-wide professional groups/communities and their role in the PPS structure; (2) development of standard performance reports to professional groups; and (3) identification of profession/peer-group representatives for relevant governing bodies.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2: Solicit input from key partners and practitioners identified during the planning process as local planning champions; revise plan.	Completed	Step 2: Solicit input from key partners and practitioners identified during the planning process as local planning champions; revise plan.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3: Plan reviewed and recommended by	Completed	Step 3: Plan reviewed and recommended by Patient and Stakeholder Engagement Subcommittee.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Patient and Stakeholder Engagement Subcommittee.									
Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Completed	Practitioner training / education plan.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Develop draft training/education plan targeting practitioners and other professional groups, designed to educate them about DSRIP and the OneCity Health quality improvement agenda.	Completed	Step 1: Develop draft training/education plan targeting practitioners and other professional groups, designed to educate them about DSRIP and the OneCity Health quality improvement agenda.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2: Solicit input from key partners and existing professional groups, and revise plan.	Completed	Step 2: Solicit input from key partners and existing professional groups, and revise plan.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3: Review and consensus-driven recommendation of plan by Care Models Subcommittee and Stakeholder & Patient Engagement Subcommittee.	Completed	Step 3: Review and consensus-driven recommendation of plan by Care Models Subcommittee and Stakeholder & Patient Engagement Subcommittee.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop Practitioners communication and engagement plan.	wy622871	Templates	52_DY2Q1_PRCENG_MDL71_PRES1_TEMPL_Practitioner_Engagement_Meeting_Schedule_Template_DY2Q1_5616.xlsx	Practitioner Engagement Meeting Schedule Template DY2 Q1	08/05/2016 11:27 AM
	jwarrick	Implementation Plan & Periodic Updates	52_DY2Q1_PRCENG_MDL71_PRES1_IMP_20160715_Practitioner_Communication_and_Engagem	Practitioner Communication and Engagement Plan	07/22/2016 05:50 PM

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			ent_Plan_4115.pdf		
Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	wy622871	Templates	52_DY2Q1_PRCENG_MDL71_PRES2_TEMPL_Practitioner_Engagement_Training_Schedule_Template_DY2Q1_5617.xlsx	Training Schedule Template DY2 Q1	08/05/2016 11:29 AM
	jwarrick	Implementation Plan & Periodic Updates	52_DY2Q1_PRCENG_MDL71_PRES2_IMP_Practitioner_Training_and_Education_Plan_4853.pdf	Practitioner Training and Education Plan	08/02/2016 03:32 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	The purpose of the Practitioner Communication and Engagement Plan is to describe OneCity Health's approach for engaging practitioners throughout the PPS in DSRIP-related planning and implementation efforts. In order to effectively engage a variety of practitioners and professional groups, this approach includes utilizing existing infrastructure, augmenting this infrastructure as needed, and developing new venues for engagement. Across various engagement structures, OneCity Health relies on a range of communication and engagement methods, catering to the needs and expertise of different group sizes and partner types. Key methods of practitioner engagement include: • In-person, small group partner engagement, such as individual partner site visits and ad-hoc cross partner workgroups. Individual partner visits from OneCity Health's borough-specific hub team provide a greater understanding of partner capabilities, needs, and interests across a wide range of partner types, including those who serve smaller populations; • In-person, larger group partner engagement, such as Project Advisory Committees (both hub-level and citywide) and ongoing meetings established with OneCity Health labor partners to improve engagement and participation; and • Other regular education and engagement channels enabling ongoing communication with partners throughout the PPS, such as webinars, the OneCity Health newsletter, and opportunities for partners to demonstrate interest in projects. To gain a better understanding of the types of practitioners across the network, OneCity Health has engaged partners through in-depth assessments to support the development of this engagement plan. As DSRIP projects are implemented throughout the city, the PPS will continue to assess the practitioner types and services provided by each of our partners to provide more targeted engagement and communication. The framework of the Practitioner Communication and Engagement Plan was reviewed by the Stakeholder and Patient Engagement Committee on June 16, 2016. The final Plan was recommended by the Committee on July 1, 2016. Please refer to the attached Practitioner Communication and Engagement Plan, Meeting Schedule Template and Performance Reports for more details.
Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	The purpose of the Practitioner Training and Education Plan is to describe OneCity Health's approach to training practitioners across professional groups in a range of areas including education on the DSRIP program and its impact, specific DSRIP projects, and the OneCity Health quality improvement agenda. The Plan describes the approach to defining topics and educational areas as well as defining learner types and modalities of training.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	In developing the Plan, training and education topics were identified through a combination of literature review, expert interviews, and insights received from frontline staff and clinical and workforce leadership from multiple partner organizations. Across the different training topics identified, the Plan defines multiple options for training modalities. These different modalities, including online and written materials, in-person trainings, webinars, and various group trainings, allow for engaging different audiences and varying training design depending on the complexity of content, difficulty of behavior change, and user acceptability. Feedback on training topics and modalities was also sought from the OneCity Health governance committees. A key component of the OneCity Health strategy for practitioner training is a plan for educating practitioners on the PPS-specific quality improvement agenda. OneCity Health is developing performance dashboards to facilitate tracking and reporting of performance metrics at the PPS-level to educate practitioners on PPS-wide performance. Additionally, OneCity Health is supporting community partners in achieving Patient-Centered Medical Home (PCMH) recognition through technical assistance provided to individual sites by technical assistance vendors. This support will also include a learning collaborative to facilitate the exchange of best practices and lessons learned between providers. The framework of the Practitioner Training and Education Plan was reviewed and recommended by the Care Models Committee on May 18, 2016. The framework of the plan was reviewed by the Stakeholder and Patient Engagement Committee on June 16, 2016, and the final plan was recommended by the Stakeholder and Patient Engagement Committee on July 1, 2016. Please see the attached Practitioner Training and Education Plan and Training Schedule Template for more details.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 7.2 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

Please describe the current level of engagement of your physician community in the DSRIP program and describe the key challenges or risks that you foresee in implementing your plans for physician engagement and achieving the milestones described above. Describe any potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk: The first major risk to the implementation is the broad geographic reach of OneCity Health providers and partners, as well as high variance in IT infrastructure and capability, which will make our engagement efforts challenging.
Mitigation: To mitigate this risk, we intend to identify clinical champions as needed and leverage our Hub-based governance structure.

Risk: The second risk we have identified is the amount of training that must be developed and deployed across OneCity Health. It will be challenging for providers and staff to adjust schedules and reduce patient/client loads in order to engage in training.
Mitigation: To mitigate this risk, we intend to develop a training/education plan that is sensitive to the busy schedules of our providers and staff. Although we don't anticipate being able to reduce the time burden associated with training, providing a rational, staged process for education that is responsive to busy schedules is one strategy to reduce the burden.

IPQR Module 7.4 - Major Dependencies on Organizational Workstreams

Instructions :

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

The training and education plan is related to activities around Workforce transformation in that all PPS training and education activities – including those targeted toward clinicians and staff – should be harmonized into a single cohesive approach.

This workstream is also highly dependent on the successful completion of planning related to clinical guidelines and process and operational workflows. This work must be largely complete before training on clinical standards and care pathways can be designed and deployed.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 7.5 - Roles and Responsibilities

Instructions :

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Support Infrastructure	OneCity Health Services: Christina Jenkins, MD, CEO; Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Accountable for development of draft practitioner engagement and training plans.
PPS Governance Entity	OneCity Health Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Review draft practitioner engagement and training plans.
PPS Governance Entity	OneCity Health Stakeholder & Patient Engagement Subcommittee	Review draft practitioner engagement and training plans.
Workforce Training Vendor	TBD	Work with Central Services Organization to develop and deploy materials and training.
Clinical Champions	Initial Champions include 50+ cross-partner Clinical Leadership Team members convened to support clinical planning; Additional champions to be identified throughout DY1-DY2 implementation process	Local practitioners identified as champions during the clinical planning process.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 7.6 - Key Stakeholders

Instructions :

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
1199 SEIU	PPS Partners	Participation on PAC and input into education and training
CIR/SEIU	PPS Partners	Participation on PAC and input into education and training
DC37	PPS Partners	Participation on PAC and input into education and training
Doctors Council	PPS Partners	Participation on PAC and input into education and training
New York State Nurses Association (NYSNA)	PPS Partners	Participation on PAC and input into education and training
United University Professions (UUP)	PPS Partners	Participation on PAC and input into education and training
Civil Service Employees Association (CSEA)	PPS Partners	Participation on PAC and input into education and training
Public Employees Federation (PEF)	PPS Partners	Participation on PAC and input into education and training
Graduate Student Employee Union	PPS Partners	Participation on PAC and input into education and training
External Stakeholders		
Other PPSs	Cross-PPS Coordination Partners	Coordination on City-wide Practitioner Engagement Approaches
NYS Dept of Health	Government agency stakeholder	Coordination on City-wide Practitioner Engagement Approaches

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 7.7 - IT Expectations

Instructions :

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

OneCity Health will implement and utilize a commercial customer relationship management (CRM) system (Salesforce.com), to manage our partner network, including physicians. The CRM will support physician communication and engagement, track phone, mail, email and other interactions, and manage engagement campaigns to reach groups of physicians.

OneCity Health will engage physicians in care management, population health management and other key aspects of DSRIP-related care coordination by building awareness of the capabilities of the planned centralized care coordination management solution (CCMS). Through demos, other events and other communications, OneCity Health will explain CCMS benefits and capabilities, focusing on how the system will help provide better service and outcomes to their patients and make their practices more efficient, allowing them to deliver higher quality patient care through functions such as:

- Providing multi-lingual, multi-cultural care navigation and support;
- Tracking and assisting patients with practice selection, active engagement in DSRIP programs, utilization tracking and pediatric-adult transition;
- Assisting patients with locating and accessing community resources, including for palliative care;
- Supporting transitions and warm handoffs at discharge, with follow-up tracking;
- Educating patients and families about wellness and care, and supporting patients in self-management and shared decision making related to their health needs; and
- Surveying patients and families regarding care experience.

In addition, physician training in evidence-based medicine, care coordination, population health management and other topics pertinent to DSRIP and OneCity Health standardization will be scheduled, delivered and tracked using a learning management system (LMS) administered by the OneCity Health Central Services Organization.

IPQR Module 7.8 - Progress Reporting

Instructions :

Please describe how you will measure the success of this organizational workstream.

We will measure success of this workstream through the completion of two deliverables: the draft practitioner engagement plan and the completion of a draft education/training plan. Because of the size and scope of the OneCity Health PPS, reporting against progress associated with the deployment of these plans will likely require both Hub-level and PPS-level reporting and management processes.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 7.9 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 08 – Population Health Management

IPQR Module 8.1 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop population health management roadmap.	In Progress	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1: Develop current-state assessment of PPS population health management capabilities and a definitive list of PCMH-eligible practices and certification status of each eligible practice through partner readiness assessment.	Completed	Step 1: Develop current-state assessment of PPS population health management capabilities and a definitive list of PCMH-eligible practices and certification status of each eligible practice through partner readiness assessment.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Based on Community Needs Assessment (CNA) data and building on application findings, identify priority target populations.	Completed	Step 2: Based on Community Needs Assessment (CNA) data and building on application findings, identify priority target populations.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Develop OneCity Health population health management future state vision schema document, incorporating feedback from key internal and external stakeholders.	Completed	Step 3: Develop OneCity Health population health management future state vision schema document, incorporating feedback from key internal and external stakeholders.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Identify IT infrastructure needed to support population health management vision.	Completed	Step 4: Identify IT infrastructure needed to support population health management vision.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 5: Identify overarching plans to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 certification by the end of DY3, and a plan to address health disparities of target populations; incorporate into overarching Population Health Management Roadmap.	Completed	Step 5: Identify overarching plans to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 certification by the end of DY3, and a plan to address health disparities of target populations; incorporate into overarching Population Health Management Roadmap.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6: Present Population Health Management Roadmap report to PPS Executive Committee for review and approval.	In Progress	Step 6: Present Population Health Management Roadmap report to PPS Executive Committee for review and approval.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #2 Finalize PPS-wide bed reduction plan.	In Progress	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: Design approach to estimate future inpatient utilization, given shift in activity to outpatient settings and DSRIP goal of reduced preventable admissions and readmissions.	In Progress	Step 1: Design approach to estimate future inpatient utilization, given shift in activity to outpatient settings and DSRIP goal of reduced preventable admissions and readmissions.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2: Estimate the potential impact of inpatient utilization changes on total PPS bed capacity needs, taking into account the drivers of inpatient supply specific to given geographies.	In Progress	Step 2: Estimate the potential impact of inpatient utilization changes on total PPS bed capacity needs, taking into account the drivers of inpatient supply specific to given geographies.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3: With appropriate stakeholder input, create report that outlines viable plan for addressing any identified excess inpatient PPS capacity.	In Progress	Step 3: With appropriate stakeholder input, create report that outlines viable plan for addressing any identified excess inpatient PPS capacity.	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 4: Present plan to PPS Executive Committee for review and approval.	In Progress	Step 4: Present plan to PPS Executive Committee for review and approval.	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop population health management roadmap.	
Finalize PPS-wide bed reduction plan.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 8.2 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

Please describe the key challenges or risks that you foresee in implementing these cross-cutting organizational strategies, including potential impacts on specific projects and, crucially, any risks that will undermine your ability to achieve outcome measure targets.

Risk: Given the size and complexity of our network, it may be difficult to quickly gain a thorough understanding of the various population health capabilities of our partners.
Mitigation: We have begun implementing a comprehensive "Partner Readiness Assessment" in order to rapidly gain an effective understanding of our network and its various population health-related assets.

Risk: Given the size and complexity of our network, and the large number of PCMH-eligible practices,
bringing all practices up to the required standards by the end of DY3 presents a challenging task. There are some PCMH eligible partners (primary care providers) who do not currently have an EHR. Being able to meaningfully use an electronic health record is important part of meeting PCMH. Depending on the timing of an EHR procurement, implementation, and training, these providers may be unable to achieve PCMH Level 3 2014 Standards by the end of DY3. The same will hold true for those eligible providers who may be beginning Meaningful Use Stage 1 Year 1 in 2016. They will likely not be far enough along (in Stage 2) in order to meet the PCMH reporting requirements by the end of DY3.
Mitigation: We plan to implement a robust "Path to PCMH" program in order to assist our eligible partners in meeting the relevant PCMH requirements by DY3 as much as possible and will be in close communication with the State on progress and emerging risks to timing as DY3 approaches.

Risk: A robust population health management capability relies on the seamless flow of information, health information exchange (HIE), across different partners and sites of care. Effectively implementing these capabilities will be slow and tedious and will require difficult decisions to be made around which platforms will be used, how the platforms will "talk" to each other, standards for tracking care management interactions, etc. An important part of our HIE strategy relies on successfully integrating our clinical provider partners to the RHIOs/SHIN-NY by the end of DY3. If the RHIOs/SHIN-NY cannot adequately meet our needs in this timeframe, or at all, then we may need to alter our strategy well into the DSRIP timeline.
Mitigation: As part of our Partner Readiness Assessment, we plan to evaluate current partners IT capabilities and from that assessment, formulate a strategy related to the implementation of a care management platform, partner connectivity and information exchange, and the development of standards for care management activities. Unfortunately, relying on the RHIOs/SHIN-NY as a central strategy for HIE places a large part of this process out of the control of OneCity Health. In an effort to mitigate the potential risks associated with the RHIOs/SHIN-NY, we are exploring the option of building our own private HIE.

IPQR Module 8.4 - Major Dependencies on Organizational Workstreams

Instructions :

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Population health management strategy will be dependent on adequately assessing and training the proper workforce to deliver care in a population health model. Population health management strategy will be dependent on ensuring that care coordination and care management services are available in a culturally competent and language- and culture-specific manner.

Population health management strategy will be dependent on ensuring the PPS has adequate care coordination and management infrastructure and health information exchange to ensure near-real time and actionable information flow and information tracking across various providers within the PPS.

Population health management strategy will be dependent on ensuring the PPS has adequate reporting, measurement, and analytics capabilities to both meet state requirements and continuously improve PPS performance.

Population health management strategy will be dependent on robust practitioner engagement, especially around the redesign of various care models to a patient- and family-centered, population health-driven model of care.

Population health management strategy will be dependent on seamless information sharing across providers and ensuring consistent use of evidence-based medicine practices.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 8.5 - Roles and Responsibilities

Instructions :

Please list and elaborate upon the key people/organizations responsible for this organizational work stream and describe what their responsibilities involve.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Strategic Planning and Operations Support	OneCity Health Services: Christina Jenkins, MD, CEO	Develop a population health management roadmap and bed reduction plan. Provide support for PCMH-eligible partners in achieving certification.
Care Coordination and Care Management Platform	Platform vendor: GSI; PPS IT Leadership team: Juan Maluf, OneCity Health Services Senior Director for IT Strategies and Implementation; Diana Amrom, OneCity Health Services IT Project Manager; Gerardo Escalera, HHC EITS DSRIP Project Management Lead	Care coordination and management vendor platform.
IT Strategy and Support	Sal Guido, Interim HHC Corporate CIO and Juan Maluf, OneCity Health Services Senior Director for IT Strategies and Implementation	Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "end state."
PPS Governance Leadership	OneCity Health Executive Committee: Ross Wilson, MD, Chair	Final approval of plans.
PPS Clinical Governance Leadership	OneCity Health Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Recommendation of plans.
HIE Qualified Entities	Bronx RHIO, Healthix, Interboro	Partner connectivity.
PCMH Support Vendor	Vendor TBD; PCMH technical assistance strategy lead: Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Provide support for PCMH-eligible partners in achieving certification.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 8.6 - Key Stakeholders

Instructions :

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Health Homes and other Care Management Organizations	VNSNY, CHN, CBC, HHC, and others	Provide care coordination & management services
Hospital partners	HHC Facilities, SUNY	Participate in care coordination & management services
Community Based Organizations	Various	Participation in patient outreach and engagement activities
External Stakeholders		
Managed Care Organizations	MetroPlus, HealthFirst and others	Provide care coordination & management services; collaborate to expand value-based payment contracting arrangements

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 8.7 - IT Expectations

Instructions :

Please describe the current Population Health Management IT capabilities in place throughout your PPS network and what your plans are at this stage for leveraging these capabilities and/or developing new IT infrastructure.

Current population health management IT capabilities in the PPS are largely at the partner or facility level. Health Homes and their care management agencies, along with other care management-focused OneCity Health partners, are using small scale care management solutions. Other partners are using homegrown analytics to track patients across settings and within condition cohorts that could be considered to be ad hoc patient registries.

A primary objective of our PPS is to develop a standard approach to population health management across all PPS partners based on a new IT infrastructure. Features will leverage tools already in place or being implemented at HHC that may not be currently utilized for population health management. Our plan for leveraging and developing a new and integrated IT infrastructure for population health management includes the following:

• Establish a centralized performance management analytics and reporting environment to store patient-level data in HHC's Business Intelligence/Enterprise Data Warehouse. HHC will optimize its performance management business intelligence analytics platform for DSRIP and population health stakeholder readiness. New capabilities will use the existing platform to create an automated registry functionality, clinical and claims based data aggregation, NYS required MDF reporting functionality for OneCity Health, and eventually dashboards with detailed information and performance analytics to support clinical programs.

• Implement a Clinical Record Locator Service (CLRS). Creating a master data management (MDM) environment and a CLRS for patient and provider matching and PPS-wide identification is a high priority. OneCity Health partners must be able to provide accurate, safe, secure, and timely exchange of patient information to providers across a multitude of facilities and systems. The foundational element of this integrated system is the ability to accurately identify and link patient records across the PPS. The CRLS will be critical for care coordination, transitions of care, and operational monitoring and reporting.

• Use the DOHMH Medicaid Analytics Provider Portal (MAPP) for additional analysis and reporting.

• Implement a common commercial care coordination and management solution (CCMS) for use across HHC and other PPS partners, which will serve as a central location for all PPS providers to enable successful population health management. We expect the platform will provide our PPS with the ability to (at a minimum): (1) risk stratify members, (2) track outreach and patient engagement, (3) create care teams and mechanisms for communication within the team, (4) document appropriate patient centered assessments, (5) create care plans, (6) track outcomes for continual improvement, and (7) receive real time event notification alerts (ADTs).

• Contract with and build interfaces to the three regional health information exchanges/Qualified Entities in OneCity Health's coverage area – Bronx RHIO, Healthix, Interboro –to achieve required data sharing among PPS partners and between electronic medical records and the CCMS, and potentially with other PPSs. This will require assessing the current state of PPS partner's IT capabilities and assessing the level of complexity

New York City Health and Hospitals Corporation (PPS ID:52)

and effort to connect. The PPS will develop and implement a phased plan for connecting partners to one of the NYC QEs beginning with high volume partners who are not already connected.

• Help partners implement certified EHRs, adopt and integrate with RHIO services and, if eligible, use the combined IT infrastructure to achieve PCMH 2014 recognition, all to perform population health management effectively and efficiently.

• Implement robust and secure IT network and communications infrastructure to support these solutions and a patient contact center that supports population health management.

IPQR Module 8.8 - Progress Reporting

Instructions :

Please describe how you will measure the success of this organizational workstream.

Success of this workstream will be measured by the following milestones, to be tracked with support from the Central Services Organization (CSO):

• Number of partners who actively use care coordination and management platform or other relevant tools;

• Number of eligible practices that have achieved NCQA PCMH recognition;

• Approval of population health management roadmap by Executive Committee; and

• Approval of bed reduction plan by Executive Committee.

IPQR Module 8.9 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 09 – Clinical Integration

IPQR Module 9.1 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	Completed	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Building on data collected as part of Partner Readiness Assessment process, collect any additional data from partners required to determine needs and capabilities with regard to: data sharing and interfaces, IT system interoperability, care coordination/ management, care transitions including ED and inpatient discharge, and care team communication.	Completed	Step 1: Building on data collected as part of Partner Readiness Assessment process, collect any additional data from partners required to determine needs and capabilities with regard to: data sharing and interfaces, IT system interoperability, care coordination/ management, care transitions including ED and inpatient discharge, and care team communication.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Based on data collected and identified best practices across the PPS network, create a clinical integration needs assessment, including mapping providers in the network, requirements, key data points for shared access, key interfaces, and other potential mechanisms to drive clinical integration.	Completed	Step 2: Based on data collected and identified best practices across the PPS network, create a clinical integration needs assessment, including mapping providers in the network, requirements, key data points for shared access, key interfaces, and other potential mechanisms to drive clinical integration.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 3: Care Models Subcommittee reviews and makes consensus-driven recommendation on needs assessment.	Completed	Step 3: Care Models Subcommittee reviews and makes consensus-driven recommendation on needs assessment.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: OneCity Health Executive Committee reviews and approves needs assessment.	Completed	Step 4: OneCity Health Executive Committee reviews and approves needs assessment.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: Through the Business Operations and IT Committee, with support from the Central Services Organization, identify the key data elements required for sharing and the key relevant systems	In Progress	Step 1: Through the Business Operations and IT Committee, with support from the Central Services Organization, identify the key data elements required for sharing and the key relevant systems	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2: Convene Clinical Leadership Team to define PPS-wide guidelines for Care Transitions through care management plans and revise on an ongoing basis through the Care Models Committee	In Progress	Step 2: Convene Clinical Leadership Team to define PPS-wide guidelines for Care Transitions through care management plans and revise on an ongoing basis through the Care Models Committee	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3: Synthesize PPS-wide Care Transitions guidelines and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	In Progress	Step 3: Synthesize PPS-wide Care Transitions guidelines and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 4: Refine Care Transitions guidelines through hub-based planning process	In Progress	Step 4: Refine Care Transitions guidelines through hub-based planning process	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5: Identify key training needs related to care coordination and communication tools as part of care management program planning process and in collaboration with the Stakeholder engagement Committee	In Progress	Step 5: Identify key training needs related to care coordination and communication tools as part of care management program planning process and in collaboration with the Stakeholder engagement Committee	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 6: Leveraging these guidelines for care transitions and data sharing elements identified by Business Operations and IT Committee, develop strategy for clinical integration that includes: clinical and other info for sharing; data sharing systems and interoperability; a specific care transitions strategy; and training for providers and operations staff.	In Progress	Step 6: Leveraging these guidelines for care transitions and data sharing elements identified by Business Operations and IT Committee, develop strategy for clinical integration that includes: clinical and other info for sharing; data sharing systems and interoperability; a specific care transitions strategy; and training for providers and operations staff.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 7: Solicit feedback from relevant stakeholders and revise strategy.	In Progress	Step 7: Solicit feedback from relevant stakeholders and revise strategy.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 8: Review and consensus-driven recommendation by Care Models Subcommittee.	In Progress	Step 8: Review and consensus-driven recommendation by Care Models Subcommittee.	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 9: Approval by OneCity Health Executive Committee.	In Progress	Step 9: Approval by OneCity Health Executive Committee.	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Perform a clinical integration 'needs assessment'.	siebeni	Other	52_DY2Q1_CI_MDL91_PRES1_OTH_OneCity_Health_List_of_Providers_5668.xlsx	Clinical Integration List of Providers	08/05/2016 01:05 PM
	jwarrick	Templates	52_DY2Q1_CI_MDL91_PRES1_TEMPL_Meeting_Schedule_Template_-_Clinical_Integration_Needs_Assessment_3935.xlsx	Clinical Integration Meeting Schedule Template	07/20/2016 12:28 PM
	jwarrick	Report(s)	52_DY2Q1_CI_MDL91_PRES1_RPT_20160715_Clinical_Integration_Needs_Assessment_vf_3934.pdf	Clinical Integration Needs Assessment	07/20/2016 12:27 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	The goal of performing a Clinical Integration Needs Assessment is to understand OneCity Health's network of providers for the complete continuum of care and to identify gaps as OneCity Health works towards system transformation. The assessment provides a framework for current and future program development at OneCity Health and forms the basis for the development of a Clinical Integration Strategy for the PPS. Multifaceted efforts to map clinical and community providers have incorporated a variety of approaches and key data sources, including: analysis of community needs and gaps in services (e.g., comprehensive Community Needs Assessment); information reported by partners on services offered and areas served (e.g., the Partner Readiness Assessment Tool and Master Partner Data Survey); and focused on-site partner capacity assessments (e.g., partner IT assessment), among others. Best practices across the OneCity Health network are identified through engaging with partners in different forums, including workgroups to discuss implementation planning; site visits and one-on-one partner conversations; clinical leadership venues within NYC Health + Hospitals; and the OneCity Health governance committee structure. For example, the borough-based Hub Steering Committees provide an opportunity for committee members to identify best practices within their geographic areas, and workgroups bring together a variety of partners with expertise in a specific topic (e.g., care transitions or palliative care integration) to identify best practices for implementation. Drawing on expertise from a range of partners, including members of the Care Models Committee, clinical leadership within NYC Health + Hospitals, and representatives of the Hub Steering Committees, OneCity Health identified clinical integration needs within the framework of six overarching categories. These include: 1) access; 2) linkage; 3) information technology; 4) integrated care; 5) care management and population health; 6) and performance management. The Clinical Integration Needs Assessment plan was recommended by the Care Models Committee on June 28, 2016. The Care Models Committee includes representatives from a range of partners and provider types and thus was the appropriate venue in which to recommend this document. The Clinical Integration Needs Assessment will be reviewed by the Executive Committee as part of the PPS Clinical Integration Strategy. Please see the attached Clinical Integration Needs Assessment, Provider List and Meeting Schedule Template for more details.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop a Clinical Integration strategy.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 9.2 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 9.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

Please describe the key challenges or risks that you foresee in improving the level of clinical integration throughout your network and achieving the milestones described above. Describe potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk: The greatest risk will be to attempt to address the full scope of the PPS's clinical integration needs without the benefit of a targeted approach with regard to clinical integration.
Mitigation: We intend to mitigate this risk by basing integration goals on prior experience with regard to high-impact integration levers, specific project and organizational requirements identified in other workstreams, and on DSRIP Domain I process measures, clinical measures, and the Special Terms and Conditions. This will enable our PPS to effectively measure progress against goals and timeframes.

Risk: Partners may be challenged, financially or otherwise, to comply with clinical integration approaches, especially those who had not previously participated in data exchange or whose IT infrastructures may not meet certified MU requirements.
Mitigation: We will educate all partners on the importance of clinical integration and incorporate clinical integration requirements into their contracts. In addition, we will take a targeted, phased approach to Clinical Integration that takes into account differing levels of partner readiness.

IPQR Module 9.4 - Major Dependencies on Organizational Workstreams

Instructions :

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

The strategies developed in the Clinical Integration workstream are closely related to requirements and strategies that will be identified in the Workforce Strategy, IT Systems and Processes, Performance Reporting, Physician Engagement and Population Health Management workstreams. In addition, the Clinical Integration workstream will be highly interdependent with General Project Implementation, particularly for Domain 2 and 3 project-specific strategies and their Domain 1 requirements. Many of the goals and requirements of project 2.a.i are closely related to clinical integration. Finally, practitioner engagement will be a core component and prerequisite for establishing a clinically integrated network.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 9.5 - Roles and Responsibilities

Instructions :

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
PPS Clinical Leadership	Anna Flattau, MD, One City Health Services Chief Clinical Officer	Oversight of clinical integration needs assessment and strategy development
Support Infrastructure	OneCity Health Services : Christina Jenkins, MD, CEO; Hub Executive Directors: Nicole Jordan-Martin (Brooklyn), Richard Bernstock (Bronx), Ishmael Carter (Queens), Manattan Hub Executive Director TBD; Hub Program Managers: Caroline Cross (Manhattan); Rachael Steimnitz (Brooklyn); Erfan Karim (Queens); Lindsay Donald (Bronx)	Network management and program management for implementation/integration support; Project management and coordination.
PPS Governance Leadership	OneCity Health Executive Committee: Ross Wilson, MD, Chair	Review and approve relevant clinical integration strategies and decisions.
PPS Governance Entity	OneCity Health Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Review clinical integration decisions and provide oversight of certain clinical integration efforts.
PPS Governance Entity	OneCity Health Business Operations & Information Technology Subcommittee: Chair TBD; staffed by Juan Maluf, OneCity Health Services Senior Director for IT Strategies and Implementation, and OneCity Health Services Finance Director	Provide input related to clinical integration in certain IT systems and processes.
PPS Governance Entity	OneCity Health Stakeholder & Patient Engagement Subcommittee	Provide advice related to integrated DSRIP clinical integration strategy.
PPS Governance Entity	OneCity Health Hub Steering Committees; staffed by Hub Executive Directors: Nicole Jordan-Martin (Brooklyn), Richard Bernstock (Bronx), Ishmael Carter (Queens), Manattan Hub Executive Director TBD	Provide input related to local implementation requirements of clinical integration strategy.
Support Infrastructure	HHC Enterprise IT Services (EITS): Gerardo Escalera, HHC EITS DSRIP Project Management Lead	Integrated OneCity Health IT strategy; QE relationships; Integration/interfaces; Overall IT implementation strategy (central and partner connectivity)
Support Infrastructure	PPS Finance Director (Permanent Director TBD)	Review clinical integration expenditures.
Providers	PPS Partners	Input into clinical integration elements and process via hub-based planning process and the Project Advisory Committee
Community Based Organizations (CBOs)	PPS Partners	Input into clinical integration elements and process via hub-based planning process and the Project Advisory Committee

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 9.6 - Key Stakeholders

Instructions :

Please identify the key stakeholders involved, both within and outside the PPS.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Attributed Patients and Families/Caregivers	Recipient of care services delivered with support of effective IT	Interaction sufficient to participate and take limited accountability for health and care-related activities
OneCity Health CSO Business and IT Staff	Accountable for project management of clinical integration initiatives PPS-wide	Oversight and integration of clinical integration into OneCity Health operations; Project management
HHC Management/Leadership	Fiduciary oversight for effective and compliant clinical integration	Oversight of clinical integration into OneCity Health operations
HHC Enterprise IT Services (EITS) Leadership and Staff	Leadership and operational support for IT-related clinical integration supports and data sharing	Coordinate, support and maintain coordinated OneCity Health (and HHC) IT solutions
Partner Organization Providers and Staff	Project management and effective adoption of OneCity Health clinical integration protocols and solutions	Adopt, implement, use and support clinical integration protocols and solutions, depending on role
Labor Unions	Awareness of how clinical integration is being used by OneCity Health	Member labor support for and training on OneCity Health clinical integration protocols, solutions and workforce supports, as warranted
External Stakeholders		
QE Management/ Leadership and Staff	Accountable for integration of key QE-supplied IT functionality for OneCity Health support	Oversight and integration of QE services into OneCity Health operations
Medicaid Managed Care Organizations (MCOs)	Awareness of how clinical integration is/can be used to serve covered members	Contribute data and participate in QE and other clinical integration solutions as warranted to effectively serve members
DOHMH	Awareness of and support for OneCity Health clinical integration	Offer solutions and guidance for compliant clinical integration in order to serve residents
NYSDOH	Provide guidance and tools for compliant clinical integration	Guidance and tools to support OneCity Health in implementing compliant clinical integration solutions
Other PPSs	Awareness of how clinical integration is being used to effectively support patients in the community and how multiple PPSs may be able support each other's clinical integration efforts	Participation in joint clinical integration planning and solution development as warranted

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 9.7 - IT Expectations

Instructions :

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

Nearly all components of OneCity Health's shared IT infrastructure will provide support for and will be critical to clinical integration. A centralized performance management and analytics environment will provide common data and outcomes measurement to bind together partners and help them track common integration results in a standardized way. A clinical record locator system and HHC-administered master data management system will provide a single integrated view of each patient and a unified, standard and navigable view of participating partners. A common care coordination management solution will add to the integrated view of the patient and provide a common tool for the care teams to interact and manage patients.

IPQR Module 9.8 - Progress Reporting

Instructions :

Please describe how you will measure the success of this organizational workstream.

Clinical Integration success will be measured according to:

• Progress against integration-related Domain 1 milestones; and

• Tracking interaction among partners in the PPS.

IPQR Module 9.9 - IA Monitoring:

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 10 – General Project Reporting

IPQR Module 10.1 - Overall approach to implementation

Instructions :

Please summarize your intended approach to the implementation of your chosen DSRIP projects, including considerations around how this approach will allow for the successful development of concurrently implementing DSRIP projects.

OneCity Health's approach to project implementation is to transform the PPS in a coordinated, measured and integrated fashion. We intend to support an implementation process that: leverages existing infrastructure; promotes partner/provider engagement and identifies areas to reduce burden; establishes clear expectations for performance; and results in high-quality patient-centered care. Key components of this approach include:

• As OneCity Health covers a large geographic area, with a broad range of partners and a diverse attributed population, we established a governance structure that would support the development of central standards that also reflect local planning. Our PPS organized its service area into four borough-based "hubs" to support a coordinated, locally-driven approach to planning. Each hub is led by a Steering Committee responsible for providing local leadership of DSRIP-related activities and reporting back to PPS-wide committees on local issues and best practices. In addition, each hub has a project advisory committee (PAC) to ensure the engagement of partners and stakeholders.

• Our clinical governance structure is designed to establish and support a process to develop clinical guidelines that provide sufficient standardization across the PPS while allowing for local flexibility. The development of clinical guidelines is aimed at identifying "must-have" elements to support our PPS in meeting DSRIP requirements and transformation goals. These PPS-wide guidelines are augmented to accommodate local variations in resources and capabilities and local operational workflows. This planning will occur primarily in DY 1; however, we anticipate revising and updating guidelines as needed. Guidelines and processes will be reviewed and recommended by the Care Models Subcommittee. This work will be supported by robust analytics and performance monitoring activities.

• To be successful in DSRIP, education, training, engagement and communication among providers and staff will be crucial. Given the breadth and depth of these needs, we must establish a coordinated plan to identify training and education needs across the PPS, establish requirements for the development and delivery of the training, and determine areas for partner participation. Training around cultural competency must be incorporated to ensure that we are responsive to the diverse needs of our attributed population.

• A robust, IT-enabled population heath approach will rely on a range of capabilities, including the capability to share data across providers and access patient-level information organized in a secure, provider-friendly electronic format. As part of this work, we conducted a preliminary partner readiness assessment to understand partner capabilities across a broad range of PPS needs. Initial data from the partner readiness assessment will inform a longer-term plan to address gaps in our network and the deployment of a comprehensive population health management strategy.

• We are establishing a workforce strategy that will address recruitment, retention and redeployment needs. The strategy will be designed around goals of meeting the primary and preventive care needs of our attributed population and addressing existing gaps in care as a result of provider shortages. We anticipate the need for expanded care management and care coordination capacity as well. A central tenet of our strategy will be to

New York City Health and Hospitals Corporation (PPS ID:52)

ensure that our workforce includes culturally and linguistically responsive providers and staff.

• We are developing an approach to financial sustainability that will enable the PPS to expand its existing and extensive value-based contracting, support the PPS infrastructure needs, leverage high standards for accountability and transparency and leverage existing infrastructure and best practices.

IPQR Module 10.2 - Major dependencies between work streams and coordination of projects

Instructions :

Please describe how your approach will handle interdependencies between complementary projects, as well as between projects and cross-cutting PPS initiatives - for example, an IT infrastructure upgrade, or the establishment of data sharing protocols.

Our overall implementation approach will rely on an adequate and effective workforce that has the training and education they need. Population health management strategy will be dependent on adequately assessing and training the proper workforce to deliver care in a population health model.

Outreach, engagement and care delivery must be provided in a way that meets the diverse language and cultural needs of our population.

Ensuring the PPS has the IT tools it needs to support care delivery, performance reporting, patient management and tracking, and care delivery is critical to almost every goal within the PPS. In addition, as part of a data-driven approach to performance improvement, our PPS must have adequate reporting, measurement, and analytics capabilities.

Finally, robust practitioner engagement, especially around the redesign of various care models, is critical to providing high-quality, patient centered care in a population health driven model.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 10.3 - Project Roles and Responsibilities

Instructions :

Please outline the key individuals & organizations that play a role in the delivery of your PPS's DSRIP projects, as well as what their responsibilities are regarding governance, implementation, monitoring and reporting on your DSRIP projects.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Support Infrastructure	OneCity Health Central Services Organization	Project management and coordination; Data analytics and performance monitoring
PPS Governance Leadership	OneCity Health Executive Committee	Oversight of DSRIP implementation and performance
PPS Governance Entity	OneCity Health Care Models Subcommittee	Guidance related to clinical quality and care model design
PPS Governance Entity	OneCity Health Business Operations & Information Technology Subcommittee	Guidance related to business functions and information technology
PPS Governance Entity	OneCity Health Stakeholder & Patient Engagement Subcommittee	Guidance related to outreach, education and communications strategies for stakeholders and patients
PPS Governance Entity	OneCity Health Hub Steering Committees	Input related to local implementation requirements of clinical integration strategy
Support Infrastructure	HHC Enterprise IT Services (EITS)	Overall IT implementation strategy (central and partner connectivity); Integrated OneCity Health IT strategy; QE relationships; Integration/interfaces

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects

Instructions :

In the below table, please set out who the key stakeholders are that play a major role across multiple DSRIP projects. Please give an indication of the role they play and how they impact your approach to delivering your DSRIP projects.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Attributed Patients and Families/Caregivers	Recipient of care services delivered with support of effective IT	Interaction sufficient to participate and take limited accountability for health and care-related activities
HHC Management/Leadership	Fiduciary oversight for effective and compliant clinical integration	Oversight of clinical integration into OneCity Health operations
OneCity Health Partners	Project management and effective project implementation	Guidance on and responsibility for project implementation, provider and staff engagement, and performance
Medicaid Managed Care Organizations (MCOs)	Support for identification, outreach and management of patients	Contribute data and participate in QE and other clinical integration solutions as warranted to effectively serve members
HHC Enterprise IT Services (EITS) Leadership and Staff	Leadership and operational support for IT-related clinical integration supports and data sharing	Coordinate, support and maintain coordinated OneCity Health (and HHC) IT solutions
External Stakeholders		
QE Management/ Leadership and Staff	Accountable for integration of key QE-supplied IT functionality for OneCity Health support	Oversight and integration of QE services into OneCity Health operations
RHIOs/SHIN-NY	Accountable for making HIE functionality available and onboarding partners	Functionality required as a result of DSRIP
DOHMH	Collaboration to support shared goals	Provide expertise and a forum for collaboration as needed
Labor Unions	Support for education and training	Support for and training on OneCity Health operational workflows

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 10.5 - IT Requirements

Instructions :

Information technology will play a crucial role in the development of an effective, integrated performing provider system. It is likely that most projects will require some level of supporting IT infrastructure. Please describe the key elements of IT infrastructure development that will play a role in multiple projects.

To support implementation and ongoing management of DSRIP projects and to act as an effective integrated delivery system, OneCity Health will require and implement a robust IT infrastructure.

- Care Coordination & Management: HHC is in the process of contracting for a care coordination management solution (CCMS) for population stratification, patient engagement, patient assessment, care planning, clinical and social service navigation, care transition management, patient registries and care management workflow, capacity and task management. HHC will implement this platform for its Health Home and OneCity Health expects to use the platform for DSRIP internally and among its PPS partners.

- Clinical Record Locator Service (CRLS): Each patient within the PPS will need a unique patient ID number that is available to providers at all points of care. OneCity Health will create a clinical record locator service for patient and provider matching and PPS-wide identification and an overarching master data management (MDM) environment. We intend to also use IBM Infosphere and Initiate tools (also known as the MDM Suite).

- Health Information Exchange: Layered on top of the unique patient ID will be a robust healthcare information exchange (HIE) that operates across PPS entities and providers that will enable the exchange of information so patient data is accurate, and patients receive the right care without unnecessary duplication of services. OneCity Health's strategy to increase the availability and utilization of health information exchanges (HIEs) will be accomplished via connectivity to various Qualified Entities (QEs) across New York City. OneCity Health will develop and implement a phased plan for connecting PPS partners to one of the NYC QEs (Bronx, Healthix, Interboro) beginning with high volume partners that are not already connected.

- Performance Management and Analytics: In order to know whether clinical programs are working and to help reduce unnecessary admissions and ED visits on an individual and population level, OneCity Health will normalize and store claims, clinical and other patient-level data in HHC's Business Intelligence/Enterprise Data Warehouse based on the IBM Provider Data Model, creating a centralized performance management, analytics and reporting capability for the PPS. OneCity Health will also use the DOHMH Medicaid Analytics Provider Portal (MAPP) for additional population health management analysis and reporting.

- Unified Communications: OneCity Health will create a foundation for data sharing among hundreds of thousands of patients and care providers in a single controlled environment through upgrades to existing technology. To provide a consistent, unified user and patient communication system, infrastructure upgrades will be made to instant messaging, presence information, telephony, video conferencing, patient portal access, desktop sharing, data sharing and call control/management systems, and unified messaging integration (integrated voicemail, e-mail, SMS and fax).

- Telehealth and telemedicine: OneCity Health will have the ability to centralize the availability and management of patient care using IT and

New York City Health and Hospitals Corporation (PPS ID:52)

communications-supported telehealth methods.

□ - Assessment, Monitoring and Support Programs and resources: Based on a current state assessment of PPS partner capabilities against OneCity Health and DOH requirements, the OneCity Health Central Services Organization will establish program management services for monitoring or assisting PPS partners as required with acquiring EHRs certified for Meaningful Use attestation, achieving NCQA 2014 PCMH recognition and participating and integrating with QEs for health information exchange.

IPQR Module 10.6 - Performance Monitoring

Instructions :

Please explain how your DSRIP projects will fit into your development of a quality performance reporting system and culture.

As the lead applicant, HHC has engaged in many quality improvement projects across facilities within the system. Similarly, many other partners within the PPS have implemented their own initiatives related to improving outcomes and performance. DSRIP will serve as a unifying force for these varied and disparate activities. OneCity Health's Central Services Organization (CSO) will serve as the infrastructure to support quality performance reporting, through the development and implementation of performance reporting formats and tools. Performance reports will integrate Domain 1 process metrics, Domain 2 and 3 quality and outcome metrics, and other internal PPS clinical and performance metrics relevant to the successful implementation of DSRIP projects and continued progress toward meeting DSRIP goals.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 10.7 - Community Engagement

Instructions :

Please describe your PPS's planned approach for driving community involvement in the DSRIP projects, how you will contract with CBOs for these projects, how community engagement will contribute to the success of the projects, and any risks associated with this.

In formulating our PPS, we were guided by several core principles. First, our PPS should be organized around the needs of the patient, the family, and the community, with an emphasis on high-quality, patient-centered care that also addresses the social determinants of health. Thus, we engaged a large number of community-based organizations (CBOs) and partners to join our PPS. Second, our PPS's ability to deliver patient-centered care depends on a well-trained workforce focused on providing seamless care across the continuum. Third, our PPS will operate transparently with a strong bias towards inclusivity. Thus, our governance structure ensures that community-based partners hold a majority of the seats on our Executive Committee, and also provides ample opportunity for local involvement and guidance. Activities that we have undertaken in this regard include:

- Taking an inclusive approach to designing its Project Advisory Committee (PAC). It is structured to both represent and include all partners within the PPS. As described previously, our governance structure also includes hub-based PACs to ensure that input into planning at both the central and local levels represents partner views and expertise. Guiding principles include committing to: a shared vision of healthier communities, meaningful collaboration, and supporting the transformation journey.
- Designing and implementing a partner readiness assessment tool. This assessment addresses a broad range of information about partner resources, capacity and readiness to implement DSRIP projects. As a result of these data, our PPS will have a much more nuanced understanding of our existing assets and resources and where we may need to develop or deploy additional supports and services.

OneCity Health anticipates contracting with CBOs to support DSRIP implementation, including to broaden the availability of social services and supports, provide education and training to patients, families, providers and staff, and to support patient identification, activation and enrollment as part of the 11th Project. Once the partner readiness assessment process is complete, we will have a better understanding of our existing assets and resources as well as gaps that must be filled. Based on this data, and through the establishment of requirements for successful implementation of each project, we will utilize the contracting process outlined in the Governance section.
One risk we have identified is that the process to identify needs, establish contracting requirements, effectuate contracts, and then provide training and education, may have a longer time horizon than is optimal for DSRIP needs. To mitigate this risk we have prioritized our work to understand current partner capabilities and gaps that may need to be filled.

IPQR Module 10.8 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending (Baseline)

Instructions :

Please include details on expected workforce spending on a semi-annual basis. Funds may be shifted from one funding type category to another within the workforce strategy spending table, as long as the PPS adheres to their overall spend commitments. However, the PPS may apply a 25% discount factor to the DY1 Workforce Strategy Spend target. If the PPS applies this discount in DY1, the PPS will be expected to reallocate those funds appropriately in DY2-4 to fully meet their DY1-4 total commitment.

Funding Type	Year/Quarter										
	DY1(Q1/Q2)($)	DY1(Q3/Q4)($)	DY2(Q1/Q2)($)	DY2(Q3/Q4)($)	DY3(Q1/Q2)($)	DY3(Q3/Q4)($)	DY4(Q1/Q2)($)	DY4(Q3/Q4)($)	DY5(Q1/Q2)($)	DY5(Q3/Q4($)	Total Spending($)
Retraining	3,750,000.00	3,750,000.00	5,312,500.00	5,312,500.00	5,312,500.00	5,312,500.00	5,312,500.00	5,312,500.00	5,312,500.00	5,312,500.00	50,000,000.00
Redeployment	375,000.00	375,000.00	531,250.00	531,250.00	531,250.00	531,250.00	531,250.00	531,250.00	531,250.00	531,250.00	5,000,000.00
New Hires	750,000.00	750,000.00	1,062,500.00	1,062,500.00	1,062,500.00	1,062,500.00	1,062,500.00	1,062,500.00	1,062,500.00	1,062,500.00	10,000,000.00
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Expenditures	**4,875,000.00**	**4,875,000.00**	**6,906,250.00**	**6,906,250.00**	**6,906,250.00**	**6,906,250.00**	**6,906,250.00**	**6,906,250.00**	**6,906,250.00**	**6,906,250.00**	**65,000,000.00**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 11.2 - Prescribed Milestones

Instructions :

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement. Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Please note some milestones include minimum expected completion dates.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	10/01/2015	06/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	Completed	Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to conduct current state survey of workforce impacted by DSRIP program.	Completed	Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to conduct current state survey of workforce impacted by DSRIP program.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify drivers of change to consider in target workforce analysis.	Completed	Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify drivers of change to consider in target workforce analysis.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify relevant populations and build target workforce state staffing scenarios.	Completed	Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify relevant populations and build target workforce state staffing scenarios.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Convene internal and external stakeholders for discussion and input on target state scenarios.	In Progress	Step 5: Convene internal and external stakeholders for discussion and input on target state scenarios.	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 6: Present target-state workforce scenarios to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations &	In Progress	Step 6: Present target-state workforce scenarios to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Information Technology Subcommittee for review and recommendation.									
Task Step 7: Present target-state workforce scenarios to PPS Executive Committee for review and approval.	In Progress	Step 7: Present target-state workforce scenarios to PPS Executive Committee for review and approval.	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	In Progress	Completed workforce transition roadmap, signed off by PPS workforce governance body.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	Completed	Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment.	Completed	Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify key milestones that PPS will need to achieve workforce transition.	Completed	Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify key milestones that PPS will need to achieve workforce transition.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to prioritize workforce transition steps.	Completed	Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to prioritize workforce transition steps.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify short and long term strategies to address workforce gaps; identify ability to address workforce gaps through training of existing staff or through long term strategies in partnerships with academic institutions.	Completed	Step 5: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify short and long term strategies to address workforce gaps; identify ability to address workforce gaps through training of existing staff or through long term strategies in partnerships with academic institutions.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6: Collaborate with cross-PPS vendor and	Not Started	Step 6: Collaborate with cross-PPS vendor and PPS Workforce Consortium to develop steps and corresponding	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
PPS Workforce Consortium to develop steps and corresponding timelines in order for the PPS to meet the established milestones in alignment with the DSRIP program expectations; finalize draft workforce transition roadmap.		timelines in order for the PPS to meet the established milestones in alignment with the DSRIP program expectations; finalize draft workforce transition roadmap.							
Task Step 7: Convene internal and external stakeholders for discussion and input.	Not Started	Step 7: Convene internal and external stakeholders for discussion and input.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 8: Present workforce transition roadmap document to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	Not Started	Step 8: Present workforce transition roadmap document to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 9: Present workforce transition roadmap document to PPS Executive Committee for review and approval.	Not Started	Step 9: Present workforce transition roadmap document to PPS Executive Committee for review and approval.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	In Progress	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	10/01/2015	06/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	Completed	Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment; identify key findings, patterns, and themes.	Completed	Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment; identify key findings, patterns, and themes.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to perform gap analysis to compare and contrast current workforce state to future workforce state.	In Progress	Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to perform gap analysis to compare and contrast current workforce state to future workforce state.	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 4: Convene internal and external stakeholders for discussion and input.	In Progress	Step 4: Convene internal and external stakeholders for discussion and input.	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5: Present current state assessment report and gap analysis to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	In Progress	Step 5: Present current state assessment report and gap analysis to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 6: Present current state assessment report and gap analysis to PPS Executive Committee for review and approval.	In Progress	Step 6: Present current state assessment report and gap analysis to PPS Executive Committee for review and approval.	04/01/2016	06/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Completed	Compensation and benefit analysis report, signed off by PPS workforce governance body.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	Completed	Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment.	Completed	Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify positions that will likely require retraining and future state positions of retrained employees.	Completed	Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify positions that will likely require retraining and future state positions of retrained employees.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to leverage data from current state assessment/gap analysis to	Completed	Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to leverage data from current state assessment/gap analysis to identify workforce impacts that will inform the compensation and benefit analysis.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
identify workforce impacts that will inform the compensation and benefit analysis.									
Task Step 5: Collaborate with cross-PPS vendor and PPS Workforce Consortium to assess impact of compensation and benefits for new hires, retrained, and redeployed staff, using publicly available and internal benchmarking databases for wages and benefits.	Completed	Step 5: Collaborate with cross-PPS vendor and PPS Workforce Consortium to assess impact of compensation and benefits for new hires, retrained, and redeployed staff, using publicly available and internal benchmarking databases for wages and benefits.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6: Collaborate with cross-PPS vendor and PPS Workforce Consortium to develop draft compensation and benefits analysis; convene internal and external stakeholders for discussion and input.	Completed	Step 6: Collaborate with cross-PPS vendor and PPS Workforce Consortium to develop draft compensation and benefits analysis; convene internal and external stakeholders for discussion and input.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7: Present compensation and benefits analysis to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	Completed	Step 7: Present compensation and benefits analysis to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8: Present compensation and benefits analysis to PPS Executive Committee for review and approval.	Completed	Step 8: Present compensation and benefits analysis to PPS Executive Committee for review and approval.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop training strategy.	In Progress	Finalized training strategy, signed off by PPS workforce governance body.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: Based on current state assessment report and gap analysis, identify training and pipeline development needs across the PPS, by Hub.	In Progress	Step 1: Based on current state assessment report and gap analysis, identify training and pipeline development needs across the PPS, by Hub.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2: Based on anticipated roll-out and ramp-up schedule of projects by Hub, map timing of anticipated training needs within each Hub by role and by project, specific to care setting.	In Progress	Step 2: Based on anticipated roll-out and ramp-up schedule of projects by Hub, map timing of anticipated training needs within each Hub by role and by project, specific to care setting.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task	In Progress	Step 3: Conduct gap analysis of key skills required to	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 3: Conduct gap analysis of key skills required to implement new delivery models by Hub.		implement new delivery models by Hub.							
Task Step 4: Identify partners within each Hub who have existing training capacity and resources to leverage.	In Progress	Step 4: Identify partners within each Hub who have existing training capacity and resources to leverage.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 5: For remaining training needs, contract with appropriate training vendors to meet identified needs.	In Progress	Step 5: For remaining training needs, contract with appropriate training vendors to meet identified needs.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 6: Develop draft training and pipeline development strategy document and convene internal and external stakeholders for discussion and input, including SUNY Downstate and other partners; document may include guiding principles, timing projections, and tactics to pursue—by Hub, by care setting, and by job classification.	In Progress	Step 6: Develop draft training and pipeline development strategy document and convene internal and external stakeholders for discussion and input, including SUNY Downstate and other partners; document may include guiding principles, timing projections, and tactics to pursue—by Hub, by care setting, and by job classification.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 7: Present training and pipeline development strategy document to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	Not Started	Step 7: Present training and pipeline development strategy document to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 8: Present training and pipeline development strategy document to PPS Executive Committee for review and approval.	Not Started	Step 8: Present training and pipeline development strategy document to PPS Executive Committee for review and approval.	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

NYS Confidentiality – High

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	jwarrick	Report(s)	52_DY2Q1_WF_MDL112_PRES4_RPT_OneCity_Health_Workforce_Compensation_and_Benefits_Report_Final_4886.pdf	OneCity Health Workforce Compensation and Benefits Report	08/02/2016 04:52 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	OneCity Health is working within a collaborative of four PPSs that have contracted with consultant BDO to achieve certain workforce deliverables. While BDO has completed the analyses on the originally-stated timeline, the PPS is moving the submission date to DY2 Q2 to ensure labor partners and other stakeholders are maximally engaged. OneCity Health is working with these partners and stakeholders to educate, review and collect input on the analyses to determine implications of and applicability to the active restructuring of the NYC healthcare ecosystem.
Create a workforce transition roadmap for achieving defined target workforce state.	
Perform detailed gap analysis between current state assessment of workforce and projected future state.	OneCity Health is working within a collaborative of four PPSs that have contracted with consultant BDO to achieve certain workforce deliverables. While BDO has completed the analyses on the originally-stated timeline, the PPS is moving the submission date to DY2 Q2 to ensure labor partners and other stakeholders are maximally engaged. OneCity Health is working with these partners and stakeholders to educate, review and collect input on the analyses to determine implications of and applicability to the active restructuring of the NYC healthcare ecosystem.
Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	OneCity Health, in coordination with three other PPSs, contracted with BDO Consulting, LLC to assist with the collection and analysis of workforce compensation data pertaining to the PPS's current and future workforce. The analysis herein anticipates the impact on OneCity Health's retrained, redeployed, and newly hired staff to fulfill workforce needs as a result of project implementation. Please reference the attached report, approved by both the OneCity Health Executive Committee and the Workforce Committee, which is a subcommittee to the Stakeholder and Patient Engagement Committee.
Develop training strategy.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 11.3 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

Please describe the key challenges and risks that you foresee in achieving the milestones set out above, including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk: Given the size and complexity of our network, it may be difficult to quickly gain a thorough understanding of the workforce of our PPS.
Mitigation: We have implemented a comprehensive "Partner Readiness Assessment" in order to quickly gain an understanding of our network and its various workforce capabilities. In addition, we are collaborating with a cross-PPS consortium to contract with a vendor to conduct a cross-PPS workforce analysis that will take into account the overlapping nature of our partner networks.

Risk: Given the rapidly evolving healthcare landscape in New York City, and the challenge of coordinating not only with our hundreds of partners but also with other PPSs with overlapping service areas, the 'Future State' of our workforce will be an evolving target. Indeed, our ability to successfully execute the DSRIP projects will be dependent on coordination and alignment with other PPSs with respect to standardized roles and responsibilities, hiring, and training. This will also require coordination with large partners in multiple PPSs.
Mitigation: We are coordinating with several other PPSs as a consortium to collaborate on a cross-PPS workforce analysis through a common vendor. We also plan to continue to coordinate regularly with other PPSs and large partners in multiple PPSs, to the extent possible, on our collective workforce transformation efforts.

Risk: Given that the entirety of New York State is undertaking this effort concomitantly, demand may exceed supply for certain roles, such as primary care practitioners, care managers, care navigators, etc.
Mitigation: As part of our workforce transformation efforts, we will seek to retrain or redeploy existing PPS employees to the extent possible for care management and navigator positions, and will seek to partner with community-based primary care practices to limit any shortages within our service area.

IPQR Module 11.5 - Major Dependencies on Organizational Workstreams

Instructions :

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

Workforce transformation will be dependent on robust practitioner engagement, especially around the redesign of various care models to a patient- and family-centered, population health-driven model of care that will implicate the hiring, re-deployment, and re-training of much of our workforce.

Workforce transformation will also be highly dependent on the clinical and operational plans emerging from project implementation planning, which will identify future state functionalities related to care management and coordination that will drive target-state workforce planning.

Workforce transformation will be dependent on the population health management workstream, especially as it relates to PCMH certification of all

New York City Health and Hospitals Corporation (PPS ID:52)

eligible practices and the related requisite care team retraining and care coordination/management capabilities that will be required.

The funds flow to support workforce transformation will be dependent on the financial analysis and governance provided by the Business Operations & Information Technology Subcommittee.

Finally, workforce transformation will be dependent on adoption of new care management and other related technology systems to support robust population health management capabilities.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 11.6 - Roles and Responsibilities

Instructions :

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Workforce Analysis Vendor	TBD (cross-PPS RFP in process)	Cross-PPS analysis of workforce current state and support in development of target state
Support Infrastructure	PPS Central Services Organization- OneCity Health Services: Christina Jenkins, MD, CEO; Anna Flattau, MD, Chief Clinical Officer; Hub Executive Directors: Nicole Jordan-Martin (Brooklyn), Richard Bernstock (Bronx), Ishmael Carter (Queens), Manhattan Hub Executive Director TBD; Hub Program Managers: Caroline Cross (Manhattan); Rachael Steimnitz (Brooklyn); Erfan Karim (Queens); Lindsay Donald (Bronx)	Working with Workforce Analysis Vendor, develop target workforce state, current state assessment report & gap analysis, workforce transition roadmap, final training strategy, and compensation and benefit analysis report
PPS Governance Leadership	OneCity Health PPS Executive Committee: Ross Wilson, MD, Chair	Approve target workforce state, current state assessment report & gap analysis, workforce transition roadmap, final training strategy, and compensation and benefit analysis report
PPS Governance Entity	OneCity Health Stakeholder & Patient Engagement Subcommittee	Review and recommend target workforce state, current state assessment report & gap analysis, workforce transition roadmap, final training strategy, and compensation and benefit analysis report
PPS Governance Entity	OneCity Health Business Operations & Information Technology Subcommittee	Review and recommend target workforce state, current state assessment report & gap analysis, workforce transition roadmap, final training strategy, and compensation and benefit analysis report
Workforce Training Vendor	1199 and others	Work with Central Services Organization to develop final training strategy and deliver training, as appropriate

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 11.7 - Key Stakeholders

Instructions :

Please identify the key stakeholders involved in your workforce transformation plans, both within and outside the PPS.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Human Resources stakeholders	PPS Partner HR organizations	Input into workforce transformation planning.
SUNY Downstate	PPS Partners	Participation on PAC and input into workforce transformation planning.
1199 SEIU	PPS Partners	Participation on PAC and input into workforce transformation planning.
CIR/SEIU	PPS Partners	Participation on PAC and input into workforce transformation planning.
DC37	PPS Partners	Participation on PAC and input into workforce transformation planning.
Doctors Council	PPS Partners	Participation on PAC and input into workforce transformation planning.
New York State Nurses Association (NYSNA)	PPS Partners	Participation on PAC and input into workforce transformation planning.
United University Professions (UUP)	PPS Partners	Participation on PAC and input into workforce transformation planning.
Civil Service Employees Association (CSEA)	PPS Partners	Participation on PAC and input into workforce transformation planning.
Public Employees Federation (PEF)	PPS Partners	Participation on PAC and input into workforce transformation planning.
Graduate Student Employee Union	PPS Partners	Participation on PAC and input into workforce transformation planning.
DOHMH	Government agency stakeholder	Coordination on City-wide Workforce Strategy.
External Stakeholders		
Other PPSs	Cross-PPS Coordination Partners	Coordination on City-wide Workforce Strategy.
NYS Dept of Health	Government agency stakeholder	Coordination on City-wide Workforce Strategy.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 11.8 - IT Expectations

Instructions :

Please describe how the development of shared IT infrastructure across the PPS will support your plans for workforce transformation.

Learning Management Software: The PPS will require learning management software in order to track training across the PPS.

Partner Management Database and other Workforce Tracking Systems: The PPS will require a robust database to track and manage workforce (and other) related data associated with the PPS partner network. This database will be initially populated through an extensive partner readiness assessment with periodic updates.

IPQR Module 11.9 - Progress Reporting

Instructions :

Please describe how you will measure the success of this organizational workstream.

We define success as the development of a comprehensive, PPS-wide workforce strategy that ensures that the PPS workforce of the future has the capacity and skill sets that it needs. Fulfillment of the milestones for this workstream will reflect our progress in collaboratively developing and implementing a robust workforce transformation strategy. The key stakeholders responsible for each core component of the workforce transformation strategy will also ensure that methods are established for data collection and analysis, as well as periodic data reporting.

Success will ultimately be measured by:
- Completion of target workforce state identification
- Completion of current state workforce assessment
- Completion of gap analysis
- Completion of workforce roadmap
- Completion of training strategy
- Number of people retrained
- Number of people redeployed
- Number of people newly hired
- Amount spent on retraining
- Amount spent on redeployment
- Amount spent on new hires

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 11.10 - Staff Impact

Instructions :

Please upload the Workforce Staffing Impact (Baseline) table provided for quarterly reporting.

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
wy622871	Other	52_DY2Q1_WF_MDL1110_OTH_Blank_Document_4684.docx	Blank document	08/01/2016 05:23 PM

Narrative Text :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 11.11 - Workforce Strategy Spending (Quarterly):

Instructions :

Please include details on workforce spending for DY2. The workforce spending actuals should reflect only what was spent during the relevant quarters and is not cumulative across semi-annual periods. The PPS can shift funding across categories; e.g., from Retraining to New Hires. Please note that the "Cumulative Percent of Commitments Expended through Current DSRIP Year (DY2)" section is calculated based on the total yearly commitments.

Benchmarks	
Year	**Amount($)**
Total Cumulative Spending Commitment through Current DSRIP Year(DY2)	23,562,500.00

Funding Type	Workforce Spending Actuals		Cumulative Spending to Date (DY1-DY5)($)	Cumulative Percent of Commitments Expended through Current DSRIP Year (DY2)
	DY1(Q1/Q2)($)	DY1(Q3/Q4)($)		
Retraining	0.00	0.00	8,234,152.00	45.43%
Redeployment	0.00	0.00	0.00	0.00%
New Hires	0.00	0.00	0.00	0.00%
Other	0.00	0.00	0.00	0.00%
Total Expenditures	**0.00**	**0.00**	**8,234,152.00**	**34.95%**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 11.12 - IA Monitoring:

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project 2.a.i – Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management

IPQR Module 2.a.i.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

There are a range of risks to the success of this project. First, many patients will face challenges becoming engaged in their own health care and in prevention activities. To mitigate this risk we intend to work with our partners to identify, engage, and track patients–with special focus on low- and non-utilizers and the uninsured, who represent an opportunity to reduce preventable hospitalizations and ED admissions. Working with CBO partners, we also intend to expand PPS cultural competency and health literacy programs.

Second, the scale and scope of PPS partner support required to meet a number of requirements (e.g., 2014 Level 3 PCMH recognition, connectivity to the RHIO/SHIN-NY) is a risk to meeting the DSRIP DY3 implementation deadline. While many clinics in our PPS eligible to meet NCQA PCMH recognition have already achieved such recognition, it is according to the 2011 standards. In addition, we expect that a number of smaller providers have yet to embark on the PCMH transformation journey. Also, while many within the PPS are using a meaningful use certified EHR, some are not and only some facilities are currently able to share data. We intend to mitigate our health IT and PCMH risks with two main strategies: (1) collaborating closely with IT and PCMH experts within our PPS to determine what support services need to be developed and deployed; (2) prioritizing practices most in need of support, either because they are a priority partner or they are most at risk of not achieving recognition.

Next, the large and diverse service area and population attributed to our PPS could present a risk in terms of meeting a broad range of varying needs across our service area. To mitigate this risk, we have established a governance structure organized into four borough-based hubs, each with a Project Advisory Committee (PAC) and Steering Committee to ensure PPS consistency while enabling responsiveness to local issues and opportunities. With Hub and City-wide members, this structure will enable us to balance local needs with broader population health goals.

We are also concerned about the limited guidance which defines which project requirements apply to different classes of providers. While we made provider speed and scale commitments in our application, this was done without complete information about how the state defined all providers (i.e., all providers to whom project requirements were relevant or all providers). As a result, we believe there is a risk associated with meeting these commitments. To mitigate this risk, we intend to continue to work with the State to identify a solution.

Additionally, our PPS is the predominant public provider in New York City, providing the majority of care to most of the city's Medicaid and uninsured residents. This population is likely to be challenging to engage and is disproportionately affected by social determinants of health. To mitigate this risk, we will undertake a number of strategies, many of which will address similar risks identified as part of other projects. For example, we intend to work with partners that have expertise addressing psycho-social risk factors as part of our ED Care Triage (2.b.iii) and 30-Day Care Transitions (2.b.iv) projects. As part of the "11th Project" (2.d.i), we intend to work closely with CBOs to conduct outreach to hard-to-engage populations.

Finally, we anticipate a risk in engaging the diverse and large number of providers in our PPS. To mitigate this risk we intend to undertake several

strategies: identify clinical champions as needed to build support across the PPS provider network; phase-in certain projects in order to improve the implementation approach and learn best practices related to implementation; and develop and deploy, as needed, assistance to low-performing providers struggling with implementing IDS population health requirements.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.a.i.2 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	DY4 Q4	Project	N/A	In Progress	01/01/2016	03/31/2019	01/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on PPS network capacity and capabilities. Educate partners on PRAT and roll out PRAT.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Analyze current state baseline PRAT data to ensure robust PPS network capacity across all geographies and all components of the care continuum, including medical, behavioral, post-acute (home care, hospice, SNF), long-term care, and community-based service providers.		Project		Completed	07/01/2015	12/30/2015	07/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task Step 3: Incorporate baseline data into partner management database to track all identified partners in the IDS.		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 4: Draft Master Services Agreement and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure (collectively, the "Base Agreement").		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 5: Solicit comments from partners.		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 6: Finalize Base Agreement.										
Task Step 7: Develop and finalize project schedules in concert with Clinical Operational Plans.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 8: Review and negotiate project schedules and budgets with partners in priority order developed by the PPS Executive Committee.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 9: Execute agreements with all PPS providers.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	DY2 Q4	Project	N/A	In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS produces a list of participating HHs and ACOs.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Conduct regular coordination meetings with partnering Health Homes to review outreach/enrollment data, develop collaborative care practices, and share best practices.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Conduct landscape assessment of HHC's ACO population health management systems and capabilities and incorporate findings into partner management database.		Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: In collaboration with partnering Health Homes, develop approach to determine how Health Homes can augment PPS systems and capabilities to implement the strategy toward evolving into an IDS, including coordination of Health Home referral patterns across the PPS.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Use ACO and Health Homes population management tracking ability to report and chart the behavior and care patterns of PPS Health Home and ACO populations.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 5: Integrate ACO and Health Home identifiers with other sub-population identifiers to enable population-level risk stratification.		Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	DY2 Q4	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS trains staff on IDS protocols and processes.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Define PPS approach to identify population health and social support needs, including Community Needs Assessments and tactics that address the needs of specific sub-populations such as patients with mental health and/or substance abuse diagnoses.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Identify available community and social supports within geographic areas and create database of these service providers.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Establish PPS-wide clinical guidelines and operational processes for global risk stratification, eligibility criteria for care management services, and minimum set of services to be delivered as part of targeted care management programs, and process for tracking care outside of hospitals. Services for certain sub-populations may include peer support or community-based care navigation.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. For patients with rising/high risk health/social support		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
needs, develop the minimum elements of a comprehensive care plan to be used with patients which identifies needed health care and community supports, including medical and behavioral health, post-acute care, long-term care and public health services.										
Task Step 5: For low risk patients, identify process and infrastructure to ensure that information on full scope of support services available by geography is available to providers and accessible by patients		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6. Develop short and long-term training and implementation plan to deploy comprehensive care plans across the PPS, using a phased approach that reflects key IT system interdependencies.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Design and deploy communication strategies to PPS partners, including community-based organizations, to educate providers and patients on available care management and other PPS services.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Using partner management system, identify participating providers lacking Clinically Interoperable Systems and develop plan to address gaps.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Produce report demonstrating that a Clinically Interoperable System is in place for all participating providers.		Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Nursing Home	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 4: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 7: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.		Project		On Hold	10/01/2015	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 4: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Develop target completion dates for each provider to obtain a certified EHR system.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	DY4 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness Assessment Tool and in-depth interviews with representative care management providers and primary care practices.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "end state."		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, including training requirements.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Produce report summarizing availability of registry functionality across PPS.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	DY3 Q4	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Conduct a gap analysis by key PCMH care model domain		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
across eligible practices and determine cost and feasibility of closing gaps										
Task Step 3: Identify cost-effective options to support partners in reaching MU for existing systems or guidance on which MU-certified EMRs are available in the marketplace		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers (see steps under Requirement #5).		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Conduct periodic assessments of primary care network capacity and access levels using customer relationship management tool and existing survey data measuring patients' perceptions of access levels.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 9: Leverage best practices in operational and process improvement to support practices, as appropriate, in improving access levels.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	DY4 Q4	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Medicaid Managed Care contract(s) are in place that include value-based payments.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1: Determine current MCO contracts in place and identify opportunities to expand value-based contracting arrangements across providers and target populations.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 2: Develop initial plan to expand MCO value-based contracts across the system, identifying priority opportunities, needed infrastructure, reporting requirements and negotiation strategies.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 3: Determine structure of legal entity (or entities) to be created for contracting.		Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Negotiate value-based payment contract with at least one MCO.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Initiate plan to expand value-based payment opportunities for new target populations and with new payers, as appropriate.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	DY2 Q4	Project	N/A	In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Identify MCOs with which to schedule monthly progress meetings, using existing MCO penetration among PPS attributed lives as a key identification criteria.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Identify any standing agenda items and key metrics that will be reviewed in monthly meetings.		Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Launch series of regular monthly meetings, using initial meetings to identify key short and long-term objectives of meeting structure.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	DY4 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation										
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Identify current value-based compensation models used in the PPS.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Define universe of relevant outcome measures in alignment with Medicaid MCO, HARP, and DOH requirements.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Develop provider incentive-based compensation model(s) across PPS clinical programs that reward achievement of patient outcomes.		Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Solicit feedback on model(s) from key stakeholders; review and consensus-driven recommendation of model(s) by Business Operations & Information Technology Subcommittee and Care Models Subcommittee.		Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Through Stakeholder Engagement Committee, develop communication plan that addresses the needs of providers across key care settings (e.g., PCMH, mental health providers). Solicit feedback on plan from key stakeholders.		Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Pilot and evaluate new incentive-based compensation models and develop plan for broader roll-out.		Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	DY4 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop objectives and components of the community outreach plan to achieve patient engagement with the PPS, taking into account the unique community needs and network capacity within each Hub.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 2: Conduct assessment of current resources in the community, by Hub.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3. Identify the timing, resource requirements and culturally-competent expertise to launch the community outreach plan.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Implement the community outreach plan, within the context of the PPS care management and patient engagement strategies.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Develop and implement tools to track, on an on-going basis, levels of community engagement and identify priority areas for further engagement efforts by the PPS.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	
Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	The absence of community level consent across the PPS has hindered OneCity Health"s ability to establish connectivity priorities. In order to effectively provide support resources, consent across partners in different Qualified Entities (QEs) and the ability to aggregate information for attributed members across PPSs must be resolved in conjunction with adaptations to the applicable state regulations. The end date for step 6 of milestone 4 is being pushed back to DY2 Q3 to allow for additional time for resolution.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	The absence of consent across PPSs has limited OneCity Health's ability to develop coordination strategies for shared partners with other PPSs, particularly with those in different Qualified Entities (QEs). Step 3 of milestone 5 is being put on hold until further New York State Department of Health guidance regarding consent across PPSs with shared partners. The delayed announcement and distribution of the Capital Restructuring Financing Program (CRFP) award has deferred the timeline for OneCity Health's Population Health IT strategy. In response, the end date of step 4 of milestone 5 is being changed to DY2 Q3. The delivery of the award has enabled the PPS to proceed with identifying cost-effective approaches to oversee implementation and training for partners pursuing an EHR transition. OneCity Health is working to assess current IT capabilities throughout the PPS in order to best cater support to partners pursuing an EHR transition. A PPS-wide assessment was conducted to evaluate present IT functionality. In addition, a baseline assessment is being conducted among eligible Patient-Centered Medical Home (PCMH) sites to evaluate readiness, including IT utilization, towards achieving PCMH Level 3 certification.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	
Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	
Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.a.i.3 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment narrative	chengc2	Other	52_DY2Q1_PROJ2ai_MDL2ai3_PPS1591_OTH_2a_Mid-Point_Assessment_Project_Narrative_Template_IDS_vf1_5643.pdf	OneCity Health Mid-Point Assessment narrative - 2.a.i	08/05/2016 11:58 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.a.i.4 - IA Monitoring

Instructions :

Project 2.a.iii – Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services

IPQR Module 2.a.iii.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

We anticipate that a significant risk facing the PPS is the fragmented set of care management programs available to populations attributed to the PPS. The programs have different and often overlapping populations, program structures, staffing models, and services. To mitigate this risk, our PPS is in the midst of developing an integrated care management strategy which will engage representatives from OneCity Health partnership, including HHC, primary care practices, Health Homes, and MCOs. The goal will be to understand how various care management programs work in concert with one another and to determine optimal approaches to coordination. This includes the development of standard policies, procedures, care pathways and clinical protocols related to care transitions, referral management, team-based care, and data sharing and reporting.

Another risk related to care management is the challenge associated with recruiting and training sufficient care management staff of various types and levels. To mitigate this risk, our PPS intends to work with partners to identify a pipeline of care management staff. We also intend to contract with organizations with expertise in workforce training (1199 SEIU Training and Employment Funds, SUNY Downstate Medical Center, and others) to ensure that care management staff are adequately trained.

We have also identified risks related to identification of and outreach to the target population. Based on the PPS's experience with Medicaid Health Homes and the lead applicant's experience with its Medicare Shared Savings Program activities, we anticipate that some members of the attributed population will be difficult to locate and may also be challenging to engage. To mitigate this risk, we anticipate leveraging the wealth of local knowledge and on-the-ground expertise represented by the diverse group of community-based partners within the OneCity Health PPS. We believe community-based organizations may be best-positioned to locate and outreach to some populations given this knowledge and experience.

Finally, the scale and scope of PPS partner support required to achieve 2014 Level 3 PCMH recognition is a risk to meeting the DSRIP DY3 implementation deadline. While many clinics within our PPS that are eligible to meet NCQA PCMH recognition have already achieved such recognition, it is according to the 2011 standards. In addition, we know from early partner survey data that a number of smaller providers have yet to embark on the PCMH transformation journey. We intend to mitigate this risk with two main strategies: first, we are collaborating closely with IT and PCMH experts within our PPS to determine what support services need to be developed and deployed. Second, we will prioritize practices most in need of support, either because the partner is integral to successful implementation (e.g., services impact a relatively high number of patients) or they are most at risk of not achieving recognition.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.a.iii.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY4,Q4	31,740

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	1,587	3,174	4,761	6,348
	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Warning: PPS Reported - Please note that your patients engaged to date (0) does not meet your committed amount (1,587) for 'DY2,Q1'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
chengc2	Rosters	52_DY2Q1_PROJ2aiii_MDL2aiii2_PES_ROST_20160802_2aiii_HHAR_Submission_0_4880.xlsx	DY2 Q1 Project 2.a.iii Patient Engagement Roster	08/02/2016 04:44 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

OneCity Health was unable to meet the actively engaged commitment for patient engagement speed and scale for DY2 Q1 for project 2.a.iii. NYC Health + Hospitals' Health Home is identifying staff to manage Health Home At-Risk patient caseloads. OneCity Health developed and distributed a distinct Schedule B for Health Home At-Risk outlining project specific responsibilities and payment terms to three additional partners, who are in the process of reviewing the contracts, which are expected to be executed shortly. Upon contract execution, OneCity Health will launch project 2.a.iii.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.a.iii.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Assess current baseline of care coordination programs in PPS.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Design target state for a Health Home At-Risk Intervention Program. Refine as necessary. Coordinate with collaborating PPSs, as appropriate.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Develop a Health Home At-Risk Intervention Program, leveraging current PPS resources. Modify or update program on the basis of new patient evidence or newly-endorsed best practices.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Obtain input on Program from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Review and consensus-driven recommendation on Program by Care Models Subcommittee. Validate Program with other relevant stakeholders, as needed.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Launch and rollout Health Home At-Risk Intervention Program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and	DY3 Q4	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Advanced Primary Care accreditation by Demonstration Year (DY) 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Conduct periodic assessments of true and usable primary care network capacity and access levels using customer relationship management tool and existing survey data measuring patients' perceptions of access levels.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 7: Leverage best practices in operational and process improvement to support practices, as appropriate, in improving access levels.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
clinical partners, including direct exchange (secure messaging), alerts and patient record look up.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Case Management / Health Home	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Ensure that EHR systems used by participating safety net	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.		Project		In Progress	10/01/2015	06/30/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Develop target completion dates for each provider to obtain a certified EHR system.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Assessment Tool and in-depth interviews with representative care management providers and primary care practices.										
Task Step 2: Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "target state."		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, including training requirements.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Produce report summarizing availability of registry functionality across PPS.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Procedures to engage at-risk patients with care management plan instituted.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for care management plans.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize PPS-wide guidelines and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Review and consensus-driven recommendation of PPS-wide guidelines by Care Models Subcommittee.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine care management plan guidelines through Hub-based planning process.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Monitor use of care management plans and refine guidelines as necessary.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Establish partnerships between primary care providers and the	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.										
Task Each identified PCP establish partnerships with the local Health Home for care management services.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.		Provider	Case Management / Health Home	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Educate partners and roll out PRAT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Analyze current state baseline to assess existing care management capabilities and primary care resources.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Identify care management roles, responsibilities, and processes for primary care providers and health home organizations		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Engage in contracting process with primary care and health home partners; contracts will reflect the roles, responsibilities, and processes outlined in Step 4.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Rollout and monitor performance of care management services.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.		Provider	Case Management / Health Home	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.										
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Educate partners and roll out PRAT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Analyze current state baseline to assess network resources.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Educate primary care provider partners on network resources. Develop and publish a sortable listing of network services; periodically refresh listing as network develops.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 6: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 7: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 8: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 10: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for addressing risk factor reduction and ensuring appropriate management of chronic diseases and BH/SUD comorbidities.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize PPS-wide guidelines and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Review and consensus-driven recommendation of PPS-wide guidelines by Care Models Subcommittee.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine care management plan guidelines through Hub-based planning process.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Monitor use of care management plans and refine guidelines as necessary.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Define training needs around risk factor reduction and chronic disease management.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 7: Develop educational materials that are culturally and linguistically appropriate.										
Task Step 8: Identify training resources available and create a culturally and linguistically sensitive training plan around risk factor reduction and chronic disease management.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Launch and roll out training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	
Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	
Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	The delayed announcement and distribution of the Capital Restructuring Financing Program (CRFP) award has deferred the timeline for OneCity Health's Population Health IT strategy. In response, the end date of step 3 of milestone 4 is being changed to DY2 Q3. The delivery of the award has enabled the PPS to proceed with identifying cost-effective approaches to oversee implementation and training for partners pursuing an EHR transition. OneCity Health is working to assess the current IT capabilities throughout the PPS in order to best cater support to partners pursuing an EHR transition. A PPS-wide assessment was conducted to evaluate present IT functionality. In addition, a baseline assessment is being conducted among eligible Patient-Centered Medical Home (PCMH) sites to evaluate readiness, including IT utilization, towards achieving PCMH Level 3 certification.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	
Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	
Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	
Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	OneCity Health has engaged with four (4) lead Health Home partners to expand traditional Health Home care coordination services to include patients who do not qualify for the Medicaid Health Home program. Because some of these patients will include those with one chronic condition who are at risk of worsening health due to the presence of social risk factors, care coordination provided will include comprehensive chronic disease management. This will include working closely with a patient's primary care team and helping them to self-manage their chronic conditions, as well as connecting patients with resources within One City Health's network to address identified social risk factors. Contracts outlining the project, specific responsibilities and payment terms have been developed and distributed. Partners are in the process of reviewing the contract. Step 7 of milestone 9 is being pushed back to DY2 Q4 to allow for additional time to engage with contracted partners. Upon contract execution, currently utilized educational materials from contracted partners will be assessed for culturally and linguistically appropriateness and amended as needed to cater to the project needs.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.a.iii.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment narrative	wy622871	Other	52_DY2Q1_PROJ2aiii_MDL2aiii4_PPS1592_OTH_2a_Mid-Point_Assessment_Project_Narrative_Template_HHAR_vf1_5635.pdf	OneCity Health Mid-Point Assessment - 2.a.iii	08/05/2016 11:53 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.a.iii.5 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project 2.b.iii – ED care triage for at-risk populations

IPQR Module 2.b.iii.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

One risk to successful implementation of the ED Care Triage project is overwhelming the 6 HHC hospitals that are already implementing the Center for Medicare and Medicaid Innovation (CMMI) Preventing Avoidable ED/Inpatient Use project. In addition, there is a risk of presenting guidance to these facilities that may come into conflict with or contradict CMS-approved protocols developed for the CMMI project. To address these risks, we will use a staged implementation, focusing first on hospitals that are not implementing the CMMI grant. In these hospitals we will implement the same ED Care Management components as those CMMI-funded hospitals. Once CMMI funding has ended, we will identify potential enhancements for those hospitals, such as supplementary care management and ambulatory support tools developed under DSRIP.

We have identified several risks related to primary care linkages and access. One challenge may be limited capacity at primary care clinics that hinder timely appointments. This challenge will be mitigated by one or more of the following strategies: increased staffing, increased hours provided at facilities, and coordination of primary care capacity across the PPS. To increase network capacity, we will work with appropriate partners, including federally qualified health centers (FQHCs) and community providers, to coordinate a system of extended hours and improved open access capabilities. Another risk is in meeting the project requirement around making PCP appointments for patients in the ED. First, we anticipate challenges in identifying the true or usable primary care capacity of partners, particular during evenings and weekends. Second, we are concerned that patients may not show up for appointments, which both reduces capacity and also means the patient may not get the care they need. Finally, the process of making appointments may take significant staff time. To address these risks, we intend to develop an approach to determining capacity both within HHC facilities as well as among other partners. This approach will identify technology and workflow requirements. To address concerns about no shows, we will leverage care managers to follow-up with patients about the need for and value of primary care visits. Care managers, community health workers and other staff can also identify barriers to keeping appointments (e.g., transportation), and identify resources to help patients overcome those barriers. Finally, we will take a data-driven approach to determining the optimal workflow for ED appointment making and determine where improvements may be needed.

Another risk we anticipate is in meeting the needs of particularly complex patients, such as those who are homeless. To mitigate this risk, we intend to work closely with partners with expertise in addressing psycho-social risk factors to better inform the care team of options for these patients and to address operational and/or staffing issues that impede their access to follow-up care.

Finally, the health IT capabilities required to be successful in this project present a risk. Many aspects of our ED Care Triage proposed interventions rely on enhanced IT systems to support: (1) population health management capabilities; (2) functional capabilities to support operations and measure performance; (3) care coordination and management capabilities; (4) improved connectivity within the PPS and with partners, including assistance with meeting Stage 2 Meaningful Use attestation; and, (5) health information exchange (HIE) with RHIO/SHIN-NY and private HIE. To mitigate this risk we intend to: focus on augmenting existing IT capabilities; prioritize partners that are key to being successful within this project; and, identifying the technology and implementation support services that are critical to success.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.b.iii.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	27,197

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	4,080	8,159	12,239	16,318
	Quarterly Update	10,639	0	0	0
	Percent(%) of Commitment	260.76%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
chengc2	Rosters	52_DY2Q1_PROJ2biii_MDL2biii2_PES_ROST_20160802_2biii_ED_Care_Submission_10639_4896.xlsx	DY2 Q1 Project 2.b.iii Patient Engagement Roster	08/02/2016 05:04 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

During DY2 Q1, OneCity Health engaged 10,639 patients in project 2.b.iii.

All patients engaged were successfully redirected to a primary care provider (PCP) as demonstrated by a scheduled appointment after a medical screening examination in the emergency department (ED), or were successfully redirected to a PCP while en route to the ED. Please see the attached roster with a list of each individual's first/last name and Medicaid CIN.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.b.iii.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Establish ED care triage program for at-risk populations	DY4 Q2	Project	N/A	In Progress	04/01/2015	09/30/2018	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Stand up program based on project requirements		Project		In Progress	04/01/2015	09/30/2018	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1: Convene Clinical Leadership Team to define initial PPS-wide guidelines for ED care triage program, including BH/SUD considerations. Synthesize guidelines and protocols. Refine over time.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on guidelines for ED care triage program. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on ED care triage guidelines and protocols.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine ED care triage program guidelines.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Monitor roll-out of guidelines and refine as needed.		Project		In Progress	04/01/2016	09/30/2018	04/01/2016	09/30/2018	09/30/2018	DY4 Q2
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs		Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on true and usable primary care capacity and access across the PPS service area. Educate partners on PRAT and roll out PRAT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Analyze current state baseline data to assess existing primary care capacity and access. Segment providers.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify roles, responsibilities, and processes for effective partnerships between EDs and primary care providers.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Contract with partners who intend to participate in this project, including, if applicable, community based behavioral health organizations.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 5: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 6: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 7: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.										
Task Step 8: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 9: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 10: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 11: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 12: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 13: Develop target completion dates for each provider to obtain a certified EHR system.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 14: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 15: Assess current baseline of PCP offices and EDs with encounter notification system (ENS) installed.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 16: Design and refine target state for installation and use of ENS.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 17: Develop plan for installation of ENS in PCP offices and		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
EDs, as laid out in target state.										
Task Step 18: Validate with PPS governance bodies and relevant stakeholders, as needed.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 19: Launch and roll out plan for installation of ENS in PCP offices and EDs.		Project		In Progress	01/01/2017	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	DY4 Q2	Project	N/A	In Progress	04/01/2015	09/30/2018	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.		Project		In Progress	04/01/2015	09/30/2018	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1: Convene Clinical Leadership Team to define PPS-wide protocols for connecting patients to non-emergency PCP and needed community support resources. Synthesize guidelines.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on protocols for connecting patients to non-emergency PCP & community support resources. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on protocols for connecting patients to non-emergency PCP & community support resources.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine protocols for connecting patients to non-emergency PCP & community support.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 5: Define PPS training needs on protocols for connecting patients to non-emergency PCP & community support.										
Task Step 6: Develop curriculum for training on connecting patients to non-emergency PCP & community support; identify training resources and create training plan.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Launch and roll out training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Monitor roll out of protocols and refine as needed.		Project		In Progress	04/01/2016	09/30/2018	04/01/2016	09/30/2018	09/30/2018	DY4 Q2
Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	DY2 Q4	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).		Provider	Safety Net Hospital	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll out training program on interim tracking process.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Monitor implementation of interim tracking process and refine as needed.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Determine project scope for Care Coordination and		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.										
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, and incorporate user documentation feedback.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Develop CCMS training requirements.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish ED care triage program for at-risk populations	
Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open	The delayed announcement and distribution of the Capital Restructuring Financing Program (CRFP) award has deferred the timeline for OneCity Health's Population Health IT strategy. In response, the end date of step 12 of milestone 2 is being changed to DY2 Q3. The delivery of the award has enabled the PPS to proceed with identifying

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	cost-effective approaches to oversee implementation and training for partners pursuing an EHR transition. OneCity Health is working to assess the current IT capabilities throughout the PPS in order to best cater support to partners pursuing an EHR transition. A PPS-wide assessment was conducted to evaluate present IT functionality. In addition, a baseline assessment is being conducted among eligible Patient-Centered Medical Home (PCMH) sites to evaluate readiness, including IT utilization, towards achieving PCMH Level 3 certification.
For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	
Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	
Use EHRs and other technical platforms to track all patients engaged in the project.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.b.iii.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment narrative	chengc2	Other	52_DY2Q1_PROJ2biii_MDL2biii4_PPS1593_OTH_2a_Mid-Point_Assessment_Project_Narrative_Template_ED_vf1_5634.pdf	OneCity Health Mid-Point Assessment narrative - 2.b.iii	08/05/2016 11:51 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.b.iii.5 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project 2.b.iv – Care transitions intervention model to reduce 30 day readmissions for chronic health conditions

IPQR Module 2.b.iv.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

Our proposed approach to the 30-Day Readmissions project is to implement and standardize Project RED (re-engineered discharge) at all 12 hospitals within the PPS. While 11 of 12 hospitals have implemented some components of Project RED, implementation has not been consistent across the hospitals. Project RED consists of 12 interventions and we believe that implementing all 12 components in 12 hospitals presents a risk to success because of the volume of work. To mitigate this risk, we will pursue a staged implementation. Our patient speed and scale estimates reflect this approach.

One of the Project RED components is to make follow-up medical appointments based on the patient's primary and specialty care needs. As with the ED Care Triage project (3.b.iii), we anticipate challenges in identifying the true and usable capacity of partners, particular during evenings and weekends. Second, we are concerned that patients may not show up for appointments. Patients failing to keep appointments both reduces capacity and also means the patient may not get the care they need. Finally, the process of making appointments may take significant staff time. To address these risks, we intend to develop an approach to determining capacity both within HHC facilities as well as among other partners. This approach will identify technology and workflow requirements. To address concerns about no shows, we will leverage care managers to follow-up with patients about the need for and value of primary care visits. Care managers, community health workers and other staff can also identify barriers to keeping appointments (e.g., transportation), and identify resources to help patients overcome those barriers. Finally, we will take a data-driven approach to determining the optimal workflow for appointment making during discharge planning and determine where improvements may be needed.

Another risk we anticipate is in meeting the needs of particularly complex patients, such as those who are homeless. To mitigate this risk, we intend to work closely with partners with expertise in addressing psycho-social risk factors to better inform the care team of options for these patients and to address operational and/or staffing issues that impede their access to follow-up care.

Finally, the health IT capabilities required to be successful in this project present a risk. Many aspects of the 30-Day Readmissions proposed interventions rely on enhanced IT systems to support: (1) population health management capabilities; (2) functional capabilities to support operations and measure performance; (3) care coordination and management capabilities; (4) improved connectivity within the PPS and with partners, including assistance with meeting Stage 2 Meaningful Use attestation; and, (5) health information exchange (HIE) with RHIO/SHIN-NY and private HIE. To mitigate this risk we intend to: focus on augmenting existing functionality; prioritize partners that are key to being successful within this project; and, identifying the technology and implementation support services that are critical to success.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.b.iv.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	9,379

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	1,407	2,814	4,221	5,627
	Quarterly Update	1,291	0	0	0
	Percent(%) of Commitment	91.76%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Warning: PPS Reported - Please note that your patients engaged to date (1,291) does not meet your committed amount (1,407) for 'DY2,Q1'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
chengc2	Rosters	52_DY2Q1_PROJ2biv_MDL2biv2_PES_ROST_20160802_2biv_CT_Submission_1291_4894.xlsx	DY2 Q1 Project 2.b.iv Patient Engagement Roster	08/02/2016 05:01 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

During DY2 Q1, OneCity Health engaged 1,291 patients in project 2.b.iv.

All patients engaged received a care transitions plan developed prior to discharge.

The number of patients engaged during this quarter represents 92% of our projected target. The new Transition Management program is currently underway in two hospitals. OneCity Health anticipates expanding the program to all 12 hospitals in the network in the coming months. Recruitment for this project requires hiring in a market in which recruitment is competitive, especially for nursing staff. OneCity Health engaged NYC Health +

New York City Health and Hospitals Corporation (PPS ID:52)

Hospitals Division of Home and Health Care to provide Transition Management services, and is currently discussing contracting for Transition Management services with five additional partner organizations. Please see the attached roster with a list of each individual's first/last name and Medicaid CIN.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.b.iv.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide protocols for Care Transitions Intervention Model, including partnerships with home care services and other appropriate community agencies. Synthesize guidelines.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on protocols for Care Transitions Intervention Model. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Coordinate with other PPSs in overlapping service areas to ensure consistency in transition protocols, as appropriate.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Care Models Committee reviews and makes consensus-driven recommendation on protocols for Care Transitions Intervention Model.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Through Hub-based planning process, refine protocols for Care Transitions Intervention Model.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Define PPS training needs on protocols for Care Transitions Intervention Model.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Develop curriculum for training on Care Transitions Intervention Model; identify training resources and create training plan.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 8: Launch and roll out training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: In coordination with Medicaid Managed Care Organizations (MCOs) and Health Homes (HH), determine current payment models in place and identify opportunities to expand payments for transition of care services.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: In coordination with MCOs and HHs, develop initial plan to expand payments for transition of care services, identifying priority opportunities, needed infrastructure, reporting requirements and negotiation strategies		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Determine structure of legal entity (or entities) to be created for contracting.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Initiate plan to expand payments for transition of care services, as appropriate.		Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Convene Clinical Leadership Team to define PPS-wide policies to coordinate care transitions with Health Homes and supportive housing, including roles and responsibilities at each stage of the workflow and linking eligible patients to services.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Obtain input from PAC on policies to coordinate care transitions with Health Homes and supportive housing. PAC is		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 7: Care Models Committee reviews and makes consensus-driven recommendation on policies to coordinate care transitions with Health Homes and supportive housing.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8: Through Hub-based planning process, refine policies to coordinate care transitions with Health Homes and supportive housing.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Monitor roll out of policies and refine as needed.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure required social services participate in the project.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Required network social services, including medically tailored home food services, are provided in care transitions.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on social services, including medically tailored home food services, across the PPS service area. Educate partners on PRAT and roll out PRAT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Analyze current state baseline data to assess existing social services. Segment providers.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Identify roles, responsibilities, and processes for effective partnerships between acute care hospitals and social services to support care transitions.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Contract with partners as needed.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Hospital	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide transition of care protocols that include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital. Synthesize protocols.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on protocols for early notification, transition care manager visits to patient in hospital. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on protocols for early notification, transition care manager visits to patient in hospital.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine guidelines protocols for early notification, transition care manager visits to patient in hospital.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Define PPS training needs on guidelines for protocols for early notification, transition care manager visits to patient in hospital.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Develop curriculum for training on protocols for early notification, transition care manager visits to patient in hospital; identify training resources and create training plan.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Launch and roll out training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
provider.										
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans (updated in interoperable EHR or updated in primary care provider record). Synthesize policies and procedures.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Define PPS training needs on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Develop curriculum for training on including care transition plans in the patient medical record and ensuring PCP access to care transition plans; identify training resources and create training plan.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Launch and roll out training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Ensure that a 30-day transition of care period is established.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide policies and procedures to establish a 30 day transition of care period.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on policies and procedures to establish a 30 day transition of care period. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on policies and procedures to establish a 30 day transition of care period.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine policies and procedures to establish a 30 day transition of care period.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Monitor roll out of policies and procedures and refine as needed.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll out training program on interim tracking process.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Monitor implementation of interim tracking process and		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
refine as needed.										
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Develop CCMS training requirements.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	
Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	
Ensure required social services participate in the project.	
Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	
Ensure that a 30-day transition of care period is established.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.b.iv.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment narrative	wy622871	Other	52_DY2Q1_PROJ2biv_MDL2biv4_PPS1594_OTH_2a_Mid-Point_Assessment_Project_Narrative_Template__Care_Trans_vf1_5639.pdf	OneCity Health Mid-Point Assessment narrative - 2.b.iv	08/05/2016 11:56 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.b.iv.5 - IA Monitoring

Instructions :

Project 2.d.i – Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

IPQR Module 2.d.i.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

We have identified a number of risks associated with this project. First, we must find, identify and connect with the uninsured population, including the undocumented and those without formal connection to the healthcare system. Identifying and connecting with this population will prove challenging. To mitigate this risk, we will contract and/or partner with organizations that have culturally-responsive approaches and engage trusted community leaders. We will also coordinate with CBOs that have existing relationships to the community and outreach expertise.

Our ability to be successful in overcoming cultural barriers for new immigrants -- some of whom have not had contact with a formal healthcare system -- also presents a risk. We intend to mitigate this risk by partnering with CBOs that have established relationships within these communities, and further developing our own relationships with these populations. The use of community health workers and peer educators will also support outreach and engagement efforts.

Finally, uncertainty related to workflows and dataflows presents a risk. Seamless data flow will require the deployment of mobile technology to field staff conducting assessments in the community. Challenges to deployment of these types of technologies will require additional mitigation strategies, including the use of paper tools.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.d.i.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY2,Q4	46,750

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	11,688	23,375	35,063	46,750
	Quarterly Update	13,890	0	0	0
	Percent(%) of Commitment	118.84%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
chengc2	Rosters	52_DY2Q1_PROJ2di_MDL2di2_PES_ROST_20160802_2di_Project_11_Submission_13890_4892.xlsx	DY2 Q1 Project 2.d.i Patient Engagement Roster	08/02/2016 04:59 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

During DY2 Q1, OneCity Health engaged 13,890 patients in project 2.d.i.

All patients engaged have completed the Patient Activation Measure® survey. Please see the attached roster with a list of each individual's first name, last name, and PAM ID#/Medicaid CIN. Please note, a CIN# is included for low and non-utilizing Medicaid patients.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.d.i.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	DY3 Q2	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Educate partners and roll out PRAT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Analyze current state baseline to assess existing CBO and patient activation resources.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Identify patient activation roles, responsibilities, and processes for patient activation.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Contract with CBOs.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	DY2 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patient Activation Measure(R) (PAM(R)) training team established.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
candidates and develop overall timeline for training in PAM administration and patient coaching/activation.										
Task Step 2: Develop curriculum and training for PAM administration and coaching/activation to augment the training offered under the Insignia contract.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll-out training program for core teams of PAM administrators and PAM coaching/activation experts, with realization these groups may in some cases differ in composition.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	DY2 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Analyze Community Needs Assessments to identify "hot spot" areas for UI, NU, and LU populations.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Conduct additional analysis and validation of CNA-identified "hot spot" areas by examining other available data source (e.g., census data, community surveys and reports).		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Generate outreach lists for "hot spot" areas based on attributed patients and additional information. Coordinate with collaborating PPSs, as appropriate.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Contract with CBOs to conduct outreach to identified UI, NU, and LU populations.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	DY2 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Community engagement forums and other information-gathering mechanisms established and performed.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Analyze Partner Readiness Assessment Tool (PRAT), Community Needs Assessments, and other community reports/surveys/data to understand baseline healthcare needs in		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
the PPS region. PRAT includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.										
Task Step 2: Engage community members through the PAC, Stakeholder Engagement Sub-Committee, Hub Steering Committees, and other forums on community needs. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: As needed, conduct additional surveys to better understand community healthcare needs.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	DY3 Q2	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".		Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop curriculum and training for providers in "hot spot" areas on PAM administration and coaching/activation techniques such as shared decision-making, measurements of health literacy, and cultural competency to augment the training offered under the Insignia contract.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll-out training program for providers.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.	DY2 Q4	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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• Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Work with MCOs to obtain lists of PCPs assigned to NU and LU enrollees.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Establish procedures and protocols that allow the PPS to work with MCOs to reconnect beneficiaries to his/her designated PCP.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Work with MCOs to establish information-exchange agreements, including sharing utilization reports.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	DY3 Q2	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).		Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Perform baseline analysis for each beneficiary cohort, per methodology determined by the state.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: At pre-determined intervals, conduct analyses to determine change against the baseline.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #8 Include beneficiaries in development team to promote preventive care.	DY2 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task Step 1: Through PAC and, to the extent possible, through operational governance committees, ensure patient input in the design of preventive care promotion activities. Refine as needed.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	DY3 Q2	Project	N/A	In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established		Project		In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
- Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task Step 1: Establish workflows determining how PPS partners will assess beneficiaries for PAM screening eligibility, PCP linkage, or healthcare benefit education.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Determine which partners will conduct PAM screenings, which will link beneficiaries to PCPs, and which will deliver healthcare benefit education.		Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 3: Conduct PAMs, linkages, and healthcare benefit education to eligible beneficiaries. Measure changes in PAM scores for this cohort each year.		Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 4: Work with MCOs to obtain lists of PCPs assigned to NU and LU enrollees.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Establish procedures and protocols that allow the PPS to work with MCOs to reconnect beneficiaries to his/her designated PCP.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6: Work with MCOs to establish information-exchange agreements, including sharing utilization reports.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Provide member engagement lists to relevant insurance companies at required intervals.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	DY3 Q2	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Volume of non-emergent visits for UI, NU, and LU populations increased.		Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Determine baseline non-emergent care volume for UI,		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
NU, and LU patients.										
Task Step 2: Through connecting NU and LU patients to the MCO-designated PCP, and through healthcare benefits education, seek to increase the volume of non-emergent care provided.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 3: For UI persons eligible for insurance, augment current processes as appropriate across all partner types to enroll patients in coverage.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 4: For UI persons ineligible for insurance, augment processes as appropriate across partner types to educate and provide information on HHC Options or similar services to improve access and linkage to non-emergent, longitudinal services.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	DY3 Q2	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Community navigators identified and contracted.		Provider	PAM(R) Providers	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.		Provider	PAM(R) Providers	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Educate partners and roll out PRAT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Analyze current state baseline to assess existing CBO and community navigator resources.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Identify CBO and partner roles, responsibilities, and processes for connecting patients to healthcare coverage and educating patients about community healthcare resources.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Develop culturally and linguistically appropriate		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
curriculum and training for those connecting patients to healthcare coverage and educating patients about community healthcare resources.										
Task Step 6: Identify training resources and create training plan.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Launch and roll-out training program. Refine as needed.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 8: Contract with CBOs and other partners.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	DY2 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures for customer service complaints and appeals developed.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Review existing HHC processes and resources deployed to handle complaints and provide customer service.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Adapt existing HHC policies, procedures, and processes for receiving and responding to beneficiary complaints and for providing customer service to specific needs of Project 11 program.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	DY2 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task List of community navigators formally trained in the PAM(R).		Provider	PAM(R) Providers	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Identify roles, responsibilities, and processes for community navigator patient activation and education training.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Develop curriculum and training for community navigators on PAM administration and patient activation and education		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
techniques to augment the training offered under the Insignia contract.										
Task Step 4: Launch and roll-out training program for community navigators.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	DY3 Q2	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.		Provider	PAM(R) Providers	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Identify roles, responsibilities, and processes for patient education training by community navigators.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop curriculum and training for community navigators.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Identify training resources and create training plan.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Launch and roll-out training program. Refine as needed.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 5: Track navigator placements across PPS.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	DY3 Q2	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Navigators educated about insurance options and healthcare resources available to populations in this project.		Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Identify roles, responsibilities, and processes for patient education training regarding insurance options and healthcare resources by community navigators.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Refine approach to defining current-state patient education regarding insurance options and healthcare resources. Establish cross-partner workgroup(s) to identify potential training team candidates and develop overall timeline for training in		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
patient education on insurance options and healthcare resources.										
Task Step 3: Develop curriculum and training for community navigators on patient education on insurance options and healthcare resources.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Launch and roll-out training program for community navigators.		Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	DY3 Q2	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Timely access for navigator when connecting members to services.		Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Establish policies, procedures, and processes for receiving and responding to community navigator requests.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Devlop training curriculum for provider intake staff on receiving navigator calls and requests to establish primary and preventive services for community members.		Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Launch and roll-out training program for intake staff.		Project		In Progress	03/31/2017	09/30/2017	03/31/2017	09/30/2017	09/30/2017	DY3 Q2
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness Assessment Tool and in-depth interviews with representative care management providers and primary care practices.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "end state."		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 3: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Launch and roll out training program on interim tracking process..		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Monitor implementation of interim tracking process and refine as needed.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 8: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 11: Develop CCMS training requirements.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 12: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
feedback, evaluate testing information; conduct user training.										
Task Step 13: Produce report summarizing availability of registry functionality across PPS.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	
Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	
Survey the targeted population about healthcare needs in the PPS' region.	
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	
Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	
Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	
Include beneficiaries in development team to promote preventive care.	
Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	
Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	
Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.d.i.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment narrative	wy622871	Other	52_DY2Q1_PROJ2di_MDL2di4_PPS1601_OTH_2a_Mid-Point_Assessment_Project_Narrative_Template_Project_11_vf_5090.pdf	Mid-Point Assessment narrative - Project 11	08/03/2016 03:04 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 2.d.i.5 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project 3.a.i – Integration of primary care and behavioral health services

IPQR Module 3.a.i.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

We anticipate execution risk related to resource- and infrastructure-related capacity, the significant variation in co-location models currently deployed across PPS partners, and the ability to integrate this effort with existing initiatives introduced by the partner organization or other NYS or Federal mandates. With regard to capacity, we have seen from CNA and assessment of partner staffing and physical infrastructure that at baseline we currently have inadequate capacity to meaningfully improve outcomes. We intend to mitigate this risk through several approaches: 1) for appropriate resourcing, we will optimize staffing, engage in cross-training among practice teams, optimize practice hours of operation, and optimize coordination of capacity across the PPS according to feasibility of patient access. We will also work to ensure appropriate use of psychiatrists so that psychiatrists treat the most serious BH disorders and stable patients are transferred to PCPs with psychiatric consultation available as needed. 2) For physical infrastructure, the PPS will await state capital funding award announcements with realization that underfunding will impede ability to complete planned space conversion. 3) To mitigate the capital funding risk, our implementation approach allows sites to use the IMPACT model where co-location is not feasible.

We expect that the practice sites across our PPS employ highly variable models, all under the term "co-location." The execution risk associated with this variability is the perhaps significant effort to redesign current offerings in order to employ a uniform model with well-defined requirements and common definitions of integration and co-location. We will determine the existing availability of integrated care using these definitions. Based on these data, we may adjust our implementation approach.

Another risk to implementation is the integration of this effort with the ongoing efforts to prepare for HARP implementation across a number of PPS sites representing significant patient volume. To mitigate this risk, over the last several months we have coordinated planning through weekly meetings and joint pilot site selection such that transformation efforts are maximally aligned. For maximum performance, we will continue these alignment efforts so that behavioral health frontline teams and management have the simplest possible integrated roadmap for transformation.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.a.i.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	53,239

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	7,986	15,972	23,958	31,943
	Quarterly Update	20,000	0	0	0
	Percent(%) of Commitment	250.44%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
chengc2	Rosters	52_DY2Q1_PROJ3ai_MDL3ai2_PES_ROST_20160802_3ai_PCBH_Submission_20000_4887.xlsx	DY2 Q1 Project 3.a.i Patient Engagement Roster	08/02/2016 04:57 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

During DY2 Q1, OneCity Health engaged 20,000 patients in project 3.a.i.

All patients engaged have received appropriate preventive care screenings. Please see the attached roster with a list of each individual's first/last name and Medicaid CIN.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.a.i.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	DY3 Q4	Model 1	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.			Provider	Mental Health	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Define process by which to prioritize primary care sites for co-located behavioral health services (e.g., based on patient need, site readiness including readiness for 2014 NCQA Level 3 PCMH / Advanced Primary Care Model standards, site familiarity or experience with behavioral health tools such as PHQ2/9).			Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Identify primary care sites that will provide co-located services.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.			Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.			Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Identify cost-effective options to support partners in evaluating and mapping clinical workflows			Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.											
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.			Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.			Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Identify potential regulatory issues associated with co-location of Primary Care and Behavioral Health services. Create mitigation plan for regulatory issues including applying for existing DSRIP regulatory waivers, as appropriate. Escalate regulatory concerns to State Agencies and other stakeholders, as needed.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Convene Clinical Leadership Team to define PPS-wide protocols for co-located behavioral health services at primary care practice sites, including staffing model and processes for interdisciplinary team communication. Synthesize guidelines.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 10: Obtain input from PAC on protocols for co-located behavioral health services at primary care practice sites. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 11: Care Models Committee reviews and makes consensus-driven recommendation on protocols for co-located behavioral health services at primary care practice sites.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 12: Through Hub-based planning process, refine			Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
protocols for co-located behavioral health services at primary care practice sites.											
Task Step 13: Identify hiring needs to support co-located behavioral health services at primary care practice sites.			Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 14: Define PPS training and onboarding needs on protocols for co-located behavioral health services at primary care practice sites.			Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 15: Develop curriculum for training and onboarding on protocols for co-located behavioral health services at primary care practice sites; identify training resources and create training plan.			Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 16: Launch and roll out training and onboarding program.			Project		In Progress	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 17: Pilot and roll-out co-location of behavioral health services at participating PCMH sites. Monitor roll-out and refine, as needed.			Project		In Progress	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	DY2 Q4	Model 1	Project	N/A	In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define evidence-based standards of care, including medication management and care engagement process.			Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Synthesize standards of care and obtain input			Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Work with collaborating PPSs to identify opportunities to co-develop or coordinate standards of care, as appropriate.											
Task Step 3: Review and consensus-driven recommendation of standards of care by Care Models Subcommittee.			Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Define PPS training needs on evidence-based standards of care.			Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Develop curriculum for training on evidence-based standards of care.			Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Launch and roll out training program.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Monitor roll out of protocols and refine as needed through Care Models Subcommittee.			Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	DY4 Q4	Model 1	Project	N/A	In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Policies and procedures are in place to facilitate and document completion of screenings.			Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Screenings are documented in Electronic Health Record.			Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).			Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
documentation in Electronic Health Record.											
Task Step 1: Assess existing provider capabilities to document preventive care screening and warm hand-off in EHR. Provide guidance to partners on EHR documentation.			Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Define process to complete and document preventive care screening and warm hand-off in co-located sites.			Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Define PPS training needs on process to complete and document preventive care screening and warm hand-off in co-located sites. For example: training needs may include provider (re)training, supervision, and skills training (e.g., motivational interviewing, behavioral activation)			Project		In Progress	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 4: Develop curriculum for training on process to complete and document preventive care screening and warm hand-off in co-located sites.			Project		In Progress	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 5: Launch and roll-out training program.			Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Step 6: Monitor roll out and refine process as needed.			Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine IT infrastructure needed to support patient identification and tracking.			Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task			Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.											
Task Step 3: Complete training on and deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Co-locate primary care services at behavioral health sites.	DY4 Q4	Model 2	Project	N/A	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Primary care services are co-located within behavioral Health practices and are available.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Primary care services are co-located within behavioral Health practices and are available.			Provider	Mental Health	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Define process by which to prioritize behavioral health sites for co-located primary care services (e.g., based on patient need, site readiness, need for modifications to physical plant / site).			Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Identify behavioral health sites that will provide co-located services.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.			Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.			Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Identify cost-effective options to support			Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.											
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.			Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.			Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Identify potential regulatory issues associated with co-location of Primary Care and Behavioral Health services. Create mitigation plan for regulatory issues including applying for existing DSRIP regulatory waivers, as appropriate. Escalate regulatory concerns to State Agencies and other stakeholders, as needed.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Convene Clinical Leadership Team to define PPS-wide protocols for co-located primary care services at behavioral health sites, including staffing model and processes for interdisciplinary team communication. Synthesize guidelines.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 10: Obtain input from PAC on protocols for co-located primary care services at behavioral health sites. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 11: Care Models Committee reviews and makes consensus-driven recommendation on protocols for co-located primary care services at behavioral health sites.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task			Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 12: Through Hub-based planning process, refine protocols for co-located primary care services at behavioral health sites.											
Task Step 13: Identify hiring needs to support co-located primary care services at behavioral health sites.			Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 14: Define PPS training and onboarding needs on protocols for co-located primary care services at behavioral health sites.			Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 15: Develop curriculum for training and onboarding on protocols for co-located primary care services at behavioral health sites; identify training resources and create training plan.			Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 16: Launch and roll out training and onboarding program.			Project		In Progress	04/01/2017	03/31/2019	04/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Step 17: Pilot and roll-out co-location of primary care services at participating behavioral health sites. Monitor roll-out and refine, as needed.			Project		In Progress	04/01/2017	03/31/2019	04/01/2017	03/31/2019	03/31/2019	DY4 Q4
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	DY2 Q4	Model 2	Project	N/A	In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define evidence-based standards of care, including medication management and care engagement process.			Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Synthesize standards of care and obtain input			Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Work with collaborating PPSs to identify opportunities to co-develop or coordinate standards of care, as appropriate.											
Task Step 3: Review and consensus-driven recommendation of standards of care by Care Models Subcommittee.			Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Define PPS training needs on evidence-based standards of care.			Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Develop curriculum for training on evidence-based standards of care.			Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Launch and roll out training program.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Monitor roll out of protocols and refine as needed through Care Models Subcommittee.			Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	DY4 Q4	Model 2	Project	N/A	In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.			Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Screenings are documented in Electronic Health Record.			Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).			Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Positive screenings result in "warm transfer" to			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
behavioral health provider as measured by documentation in Electronic Health Record.											
Task Step 4: Launch and roll-out training program.			Project		In Progress	07/01/2018	03/31/2019	07/01/2018	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Assess existing provider capabilities to document preventive care screening and warm hand-off in EHR. Provide guidance to partners on EHR documentation.			Project		In Progress	07/01/2017	03/31/2018	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 2: Define process to complete and document preventive care screening and warm hand-off in co-located sites.			Project		In Progress	07/01/2017	03/31/2018	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 3: Define PPS training needs on process to complete and document preventive care screening and warm hand-off in co-located sites.			Project		In Progress	04/01/2018	06/30/2018	04/01/2018	06/30/2018	06/30/2018	DY4 Q1
Task Step 4: Develop curriculum for training on process to complete and document preventive care screening and warm hand-off in co-located sites.			Project		In Progress	04/01/2018	06/30/2018	04/01/2018	06/30/2018	06/30/2018	DY4 Q1
Task Step 5: Launch and roll-out training program for PCMH staff and other team members.			Project		In Progress	07/01/2018	03/31/2019	07/01/2018	03/31/2019	03/31/2019	DY4 Q4
Task Step 6: Monitor roll out and refine process as needed.			Project		In Progress	07/01/2018	03/31/2019	07/01/2018	03/31/2019	03/31/2019	DY4 Q4
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine IT infrastructure needed to support patient identification and tracking.			Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.			Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Implement IMPACT Model at Primary Care Sites.	DY4 Q4	Model 3	Project	N/A	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Define process by which to prioritize primary care sites for implementation of IMPACT model (e.g., based on patient need, site readiness including readiness for 2014 NCQA Level 3 PCMH / Advanced Primary Care Model standards).			Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Work with partners to document behavioral health screening and services already provided at PPS primary care sites, including primary care sites that have already implemented IMPACT model.			Project		In Progress	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 3: Identify primary care sites that will implement IMPACT model.			Project		In Progress	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 4: Define PPS training needs on IMPACT model and collaborative care standards.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Develop curriculum for training program.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Launch and roll out training program.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Launch and roll-out IMPACT model – including collaborative care standards - at participating primary care sites. For sites that have already implemented			Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
IMPACT model, design and implement improvement methodologies.											
Task Step 8: Monitor roll out of IMPACT model and collaborative care standards, ensuring compliance with program standards. Make refinements to standards as needed.			Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	DY2 Q4	Model 3	Project	N/A	In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures include process for consulting with Psychiatrist.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines.			Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Synthesize guidelines and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Coordinate with other PPSs to adapt/develop training materials and curricula, as appropriate.			Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Review and consensus-driven recommendation by Care Models Subcommittee.			Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Monitor and refine as needed.			Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	DY2 Q4	Model 3	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies qualified Depression Care Manager			Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
(can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.											
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.			Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: (For participating sites) Assess PPS primary care sites for current appropriate staffing resources to fulfill depression care management role.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Identify or recruit Depression Care Manager for sites participating in IMPACT model, ensuring appropriate skill set.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Define PPS training and performance-monitoring needs for Depression Care Managers on IMPACT model and collaborative care standards.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Develop curriculum for training program.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Launch and roll out training program for PCMH staff and other team members.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Conduct periodic review of Depression Care Manager model to ensure compliance with IMPACT program standards. Make refinements as needed.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	DY2 Q4	Model 3	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.			Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: (For participating sites) Assess PPS primary care sites for current appropriate staffing resources for Psychiatrist(s).			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 2: Identify or recruit Psychiatrist for sites participating in IMPACT model.											
Milestone #13 Measure outcomes as required in the IMPACT Model.	DY4 Q4	Model 3	Project	N/A	In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).			Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Define process to measure outcomes, including process to complete and document preventive care screening in established project sites.			Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Develop curriculum and training for staff.			Project		In Progress	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 3: Identify training resources and create training plan.			Project		In Progress	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 4: Launch and roll-out training program.			Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Step 5: Measure outcomes and implement improvement methodologies at sites participating in IMPACT model.			Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	DY4 Q4	Model 3	Project	N/A	In Progress	04/01/2016	03/31/2019	04/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.			Project		In Progress	04/01/2016	03/31/2019	04/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for provision of "stepped care".			Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Synthesize guidelines on provision of "stepped care" and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other			Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
stakeholders).											
Task Step 3: Review and consensus-driven recommendation by Care Models subcommittee.			Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Define PPS training needs on provision of "stepped care." Develop curriculum for training on provision of "stepped care."			Project		In Progress	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 5: Identify training resources and develop training plan.			Project		In Progress	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 6: Launch and roll-out IMPACT model at participating primary care sites, including training			Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Model 3	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine IT infrastructure needed to support patient identification and tracking			Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.			Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.			Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Co-locate primary care services at behavioral health sites.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Implement IMPACT Model at Primary Care Sites.	
Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	
Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	
Designate a Psychiatrist meeting requirements of the IMPACT Model.	
Measure outcomes as required in the IMPACT Model.	
Provide "stepped care" as required by the IMPACT Model.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.a.i.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment narrative	wy622871	Other	52_DY2Q1_PROJ3ai_MDL3ai4_PPS1595_OTH_2a_Mid-Point_Assessment_Project_Narrative_Template_PCBH_vf1_5642.pdf	OneCity Health Mid-Point Assessment narrative - 3.a.i	08/05/2016 11:58 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.a.i.5 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project 3.b.i – Evidence-based strategies for disease management in high risk/affected populations (adult only)

IPQR Module 3.b.i.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

One of the required interventions of the Cardiovascular Project is to ensure that attributed patients are able to have a drop-in blood pressure check with no copay. We anticipate a risk associated with the administrative and nursing capacity. Larger clinics may have a more complex workflow in which to integrate this service and smaller clinics may lack capacity and staffing. To mitigate this risk we intend to work with ambulatory care practices to determine the specific barriers to implementation and develop strategies to overcome the barriers. Patients also don't come in for blood pressure checks due to transportation costs, time required, missed work time etc. To mitigate this risk, we will use home blood pressure monitors to assess patient's blood pressure with reporting via phone.

We also expect risks associated with effective engagement of chronically ill patients over the long term, particularly with regard to behavior change. To mitigate this risk we intend to deploy peer educators and care managers to support patients, with heavy reliance on the recommended evidence-based Stanford Model.

The CVD project requires clinicians to prescribe once-daily regimens or fixed-dose combination pills when appropriate. The second major risk to the project is the potential for Medicaid managed care plans to not cover either the once-daily regimen or fixed dose combination pills. Lack of coverage for the pills would likely result in a lack of adherence. To mitigate this risk, we intend to work collaboratively with other PPSs and managed care plans to optimize and unify the formulary for proven CV medications.

We have also identified risks related to health IT. Our ability to implement and report on metrics related to the project are dependent on existing registries and interoperability. To mitigate this risk we will identify specific IT requirements of the project – such as using the registry to identify existing patients who meet project inclusion criteria – and determine the best way to incorporate this functionality.

The CVD project also requires that 80% of providers be engaged. We believe engaging the majority of primary care providers (PCPs) within the PPS in this project presents a risk, given that PCPs often have very challenging schedules and making time for new quality improvement or practice transformation efforts can be challenging. To mitigate this risk, we intend to work closely with PCPs to provide education about the importance of the project. We will also identify clinical champions, as needed, to promote engagement. Our PPS may also make available clinical and practice transformation support to practices that are either lower performers or that have demonstrated limited engagement in implementation. Finally, we will use the contracting process as a lever to require PPS partners to meet project requirements.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.b.i.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	23,665

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	3,550	7,100	10,650	14,199
	Quarterly Update	3,862	0	0	0
	Percent(%) of Commitment	108.79%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
chengc2	Rosters	52_DY2Q1_PROJ3bi_MDL3bi2_PES_ROST_20160802_3bi_Cardiovascular_Submission_3862_4884.xlsx	DY2 Q1 Project 3.b.i Patient Engagement Roster	08/02/2016 04:51 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

During DY2 Q1, OneCity Health engaged 3,862 patients in project 3.b.i.

All patients engaged have received services from participating providers with documented self-management goals in their medical record. Please see the attached roster with a list of each individual's first/last name and Medicaid CIN.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.b.i.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide programs for improving management of cardiovascular disease (CVD) using evidence-based strategies in ambulatory and community care settings.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize programs for improving management of CVD and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on programs for improving management of CVD.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine programs for improving management of CVD through Hub-based planning process.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand PPS capacity for implementing evidence-based strategies for improved care of CVD. Educate partners on PRAT and roll out PRAT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task		Project		Completed	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 6: Analyze current state baseline data to assess existing provider capabilities for implementing evidence-based strategies for improved care of CVD. Segment providers.										
Task Step 7: Identify staff needed (e.g. registry coordinator, outreach manager, data manager, pharmacist, care manager, collaborative care nurses) and location (on-site vs. centralized support), roles/responsibilities, local practitioner champions and processes for implementing evidence-based strategies for improving management of CVD. As implementation progresses, modify as needed.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Roll out, monitor, and refine rollout of evidence-based strategies for improving management of CVD, as needed.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 3: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 4: Develop target completion dates for each provider to obtain a certified EHR system.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners. Refine as needed.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine IT infrastructure needed to support patient identification and tracking.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop plan to create/update patient registries to support patient identification and outreach for those with CVD conditions. Develop data reporting plan to assess data completeness of relevant EHR fields.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	DY2 Q4	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine IT infrastructure needed to support patient identification, patient tracking, and provider prompts that facilitate tobacco control protocols, including capacity for periodic self-audits.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop plan to deploy patient registries and training		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
requirements to support patient identification, patient tracking, and provider prompts.										
Task Step 3: Complete deployment of patient registries to support patient identification, patient tracking, and provider prompts.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Define PPS training needs on the use of EHRs in tobacco control protocols, develop training curriculum, and write training materials.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Create training curriculum and create training plan.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Launch and roll out training program on the use of EHRs in tobacco control protocols.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for adopting standardized treatment protocols for hypertension and elevated cholesterol that align with national guidelines.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize adoption guidelines and treatment protocols, and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on adoption guidelines and treatment protocols.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine adoption guidelines and treatment protocols through Hub-based planning process.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Identify roles, responsibilities, and processes for		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
providing standardized treatment protocols for hypertension and elevated cholesterol.										
Task Step 6: Establish contracts with partners to follow standardized treatment protocols for hypertension and elevated cholesterol.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Create training curriculum and training plan, and roll out training program.		Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 8: Monitor roll out of treatment protocols and refine as needed.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide protocols, procedures and workflows for care coordination teams to address lifestyle changes, medication adherence, health literacy issues, and patient self-management.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize care coordination clinical protocols and workflows and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on care coordination protocols and workflows.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 4: Refine care coordination guidelines through Hub-based		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
planning process.										
Task Step 5: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand partner capacity for coordinating care with other PPS partners to help patients manage lifestyle changes, adhere to medication as prescribed, and self-manage their care. Educate partners on PRAT and roll out PRAT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 6: Analyze current state baseline data to assess existing provider capabilities to coordinate care with other providers. Segment providers.		Project		Completed	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Identify staffing needs, roles, responsibilities, and processes of delivering coordinated care.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 8: Contract with partners as needed.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 9: Create training curriculum and training plan, and roll out training program		Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 10: Roll out care coordination teams, monitor performance, and refine as needed.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on care coordination protocols.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	DY3 Q4	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Assess existing provider capabilities to provide follow-up blood pressure checks without a copayment or advanced appointment.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 2: Define process to provide follow-up blood pressure checks without a copayment or advanced appointment.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2017	06/30/2017	DY3 Q1

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 3: Define PPS training needs on process to provide follow-up blood pressure checks without a copayment or advanced appointment.										
Task Step 4: Develop curriculum for training on process to provide follow-up blood pressure checks without a copayment or advanced appointment.		Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task Step 5: Launch and roll-out training program.		Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 6: Monitor roll out and refine process as needed.		Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide protocol on blood pressure measuring and recording.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize guidelines on blood pressure measuring and recording and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Refine guidelines for measuring and recording blood pressure through Hub-based planning process.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Roll out training and monitor process for measuring and recording blood pressure monitoring. Refine as needed.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Determine IT infrastructure needed to identify patients seen routinely with repeated elevated blood pressures in the medical record but no diagnosis.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Determine clinical review process and care team roles in identifying patients needing outreach and scheduling follow up BP visit.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification, tracking, and automated scheduling of follow-up visits. Plan should include training requirements.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Develop a training program, roll out training program, and track those trained on identification of patients with undiagnosed hypertension.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5: Complete deployment of CCMS and related registries to support patient identification, tracking, and automated scheduling of follow-up visits.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Roll out, monitor and refine protocol for identifying those at-risk of HTN and use of CCMS as needed.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide medication algorithm based on ease of medication adherence, efficacy, ease of titration, managed care plan formularies, and other relevant criteria.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on medication algorithm based on ease of medication adherence.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine medication algorithm based on ease of medication adherence through Hub-based planning process.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Assess current-state Medicaid Managed Care Organizations (MCO) pharmacy benefits as they relate to medication algorithm.		Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Identify opportunities to collaborate with MCOs on pharmacy benefits that will support implementation of medication algorithm.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Roll out, monitor implementation of medication algorithm and refine as needed.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Self-management goals are documented in the clinical record.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for documenting self-management goals in medical records.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize guidelines and IT requirements for documenting self-management goals in medical records and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for documenting self-management goals in medical records.										
Task Step 4: Refine guidelines for documenting self-management goals in medical records through Hub-based planning process.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Define PPS training needs, for documenting self-management goals through person-centered methods.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Develop curriculum for training on person-centered methods that include documenting self-management goals; identify training resources and create training plan.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Launch and roll out training program.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	DY3 Q4	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed referral and follow-up process and adheres to process.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Through Hub-based planning process, identify and implement agreements with community-based resources to refer patients to and distribute resource lists.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Define PPS training needs for making warm referrals and the follow-up process.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Develop curriculum for training on making warm referrals and the follow-up process.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Identify training resources and create training plan.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 5: Launch and roll out training program.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 6: Monitor and track referrals, follow-ups, documentation, and feedback, and refine process as needed.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented protocols for home blood pressure monitoring.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide clinical protocol and workflow for home blood pressure monitoring and follow-up support.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize clinical protocol and workflow for home blood pressure monitoring and follow-up support, and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on clinical protocols and workflow for home blood pressure monitoring and follow-up support.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine guidelines for home blood pressure monitoring and follow-up support.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Identify team capacity and roles, identify equipment vendor, create plan for equipment supply distribution and tracking, determine IT needs for patient tracking.		Project		On Hold	07/01/2015	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 6: Define PPS training needs for making warm referrals and following up on referrals.		Project		On Hold	07/01/2015	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 7: Develop curriculum for training on making warm referrals and the follow-up process.		Project		On Hold	07/01/2015	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 8: Identify training resources, create training plan, launch training program.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Monitor referrals, follow-ups, and documentation; refine protocol as needed.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	DY2 Q4	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Through Hub-based planning process, refine guidelines for identifying and reaching patients with hypertension.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Determine IT infrastructure/registry and reporting needed to identify patients with hypertension and automatically scheduling follow-up appointments.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification, tracking, and automated scheduling of follow-up visits. Plan should include training requirements.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Complete deployment of CCMS and related registries to support patient identification, tracking, and automated scheduling of follow-up visits.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Monitor and refine protocol for identifying and reaching patients with hypertension, and use of CCMS as needed.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	DY2 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define guidelines		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
for referring smokers to the Quitline.										
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for referring smokers to the Quitline.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine guidelines for referring smokers to the Quitline through Hub-based planning process.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Define PPS training needs on guidelines for referring smokers to the Quitline.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Develop curriculum for training on guidelines for referring smokers to the Quitline.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Launch and roll-out training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Monitor roll out and refine process as needed.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Based on Community Needs Assessment (CNA) and Medicaid Claims and Encounter data (from SIM tool), identify		Project		Completed	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
high risk neighborhoods where PPS may deploy "hot spotting" strategies for high risk populations.										
Task Step 2: Use Partner Readiness Assessment Tool (PRAT) to understand provider capacity to perform additional actions towards the better care management for high risk populations in "hot spot" areas.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 3: Analyze current state baseline data to assess existing provider capabilities connecting patients to Health Homes, facilitating group visits, implementing the Stanford Model for chronic diseases, and other additional care strategies that benefit high risk populations. Segment providers.		Project		Completed	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Identify needs, roles, responsibilities, and processes for performance of additional care activities that benefit high-risk populations.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Based on provider assessment and "hot spotting" work, contract with partners as necessary.		Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 6: Determine IT infrastructure needed to support patient identification and tracking.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Complete deployment of CCMS and related registries to support patient identification and tracking.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #18 Adopt strategies from the Million Hearts Campaign.	DY2 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.		Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.		Provider	Mental Health	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define guidelines for adopting strategies from the Million Hearts Campaign.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for adopting strategies from the Million Hearts Campaign.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine guidelines for adopting strategies from the Million Hearts Campaign through Hub-based planning process.		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Define PPS training needs on guidelines related to strategies from the Million Hearts Campaign.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Develop curriculum for training on guidelines related to strategies from the Million Hearts Campaign.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Launch and roll-out training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Monitor implementation of policies and procedures that reflect principles and initiatives of the Million Hearts Campaign. Refine as needed.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	DY3 Q4	Project	N/A	In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Review existing MCO contracts to determine gaps in		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
coverage related to coordination of services for high risk populations.										
Task Step 2: Develop agreements to address coverage gaps.		Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 3: Finalize agreements with MCO partners.		Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand partner capacity to delivery primary care to affected populations. Educate partners on PRAT and roll out PRAT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Analyze current state baseline data to assess the number of primary care providers within a PPS. Segment providers.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify roles, responsibilities, and processes for engaging primary care providers.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Contract with primary care providers as needed.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Roll out campaign to engage primary care providers. Monitor number of PCPs in the PPS and revise campaign as needed.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	
Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	The absence of community level consent across the PPS has hindered OneCity Health's ability to establish connectivity priorities. In order to effectively provide support resources, consent across partners in different QEs and the ability to aggregate information for attributed members across PPSs must be resolved in conjunction with adaptations to the applicable state regulations. The end date for step 5 of milestone 2 is being moved to DY2 Q3 to allow for additional time for resolution.
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	The delayed announcement and distribution of the Capital Restructuring Financing Program (CRFP) award has deferred the timeline for OneCity Health's Population Health IT strategy. In response, the end date of step 3 of milestone 3 is being changed to DY2 Q3. The delivery of the award has enabled the PPS to proceed with identifying cost-effective approaches to oversee implementation and training for partners pursuing an EHR transition. OneCity Health is working to assess the current IT capabilities throughout the PPS in order to best cater support to partners pursuing an EHR transition. A PPS-wide assessment was conducted to evaluate present IT functionality. In addition, a baseline assessment is being conducted among eligible Patient-Centered Medical Home (PCMH) sites to evaluate readiness, including IT utilization, towards achieving PCMH Level 3 certification.
Use EHRs or other technical platforms to track all patients engaged in this project.	
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	OneCity Health recognizes that many primary care partners have existing quality improvement initiatives to screen, counsel, and treat for tobacco cessation. The PPS will achieve meaningful success in this project by building on existing programs and training initiatives, rather than creating a new and fragmented effort. Understanding the amount and structure of this baseline work will allow OneCity Health to effectively enhance and expand tobacco-related training initiatives. OneCity Health has identified a strong existing tobacco cessation program throughout NYC Health + Hospitals' primary care sites. Primary care partners other than NYC Health + Hospitals will complete the Cardiovascular Baseline Survey that will inform the PPS training plan and curriculum for smoking cessation. The PPS's training plan and curriculum, both within and outside NYC Health + Hospitals, will be stronger for being based on an accurate understanding of existing work and of gaps that need to be filled. The end date for steps 4 and 5 of milestone 5 is being moved to DY2 Q3 to allow for additional time to conduct and analyze the Cardiovascular Baseline Survey and incorporate the results into the training plan and curriculum.
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	
Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	A phased implementation strategy has been developed for project 3.b.i to provide opportunities for piloting, rapid cycle improvement, and to better align with the end dates of the project milestones. Phase 1 focuses on implementing guidelines for the management of hypertension, measuring and recording blood pressure, and incorporating self-management of cardiovascular conditions. Phase 2 focuses on generating a registry of hypertensive patients, establishing support for home blood pressure monitoring, and standardizing screening and counseling for tobacco smoking. OneCity Health is actively implementing Phase 1 and 2 at NYC Health + Hospitals and working to scale the project further with additional partners. As part of this phased implementation strategy, providing follow-up blood pressure checks without a copayment or advance appointment will be incorporated at a later phase. The end dates of steps 1-4 of milestone 8 are being moved to DY3 Q1 to better align with the overall milestone completion date of DY3 Q4.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	
Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	
Document patient driven self-management goals in the medical record and review with patients at each visit.	
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	
Develop and implement protocols for home blood pressure monitoring with follow up support.	In developing and implementing protocols for home blood pressure monitoring with follow-up support for milestone 14 of project 3.b.i, OneCity Health will not procure and distribute equipment. Therefore, step 5 of this milestone is deleted, as it is no longer applicable to the project. Steps 6 and 7 of milestone 14 are deleted, as they are an erroneous duplication of steps 2 and 3 of the previous milestone 13.
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	
Facilitate referrals to NYS Smoker's Quitline.	
Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	
Adopt strategies from the Million Hearts Campaign.	
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	
Engage a majority (at least 80%) of primary care providers in this project.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.b.i.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment narrative	chengc2	Other	52_DY2Q1_PROJ3bi_MDL3bi4_PPS1596_OTH_2a_Mid-Point_Assessment_Project_Narrative_Template_CVD_vf1_5632.pdf	OneCity Health Mid-Point Assessment narrative - 3.b.i	08/05/2016 11:47 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.b.i.5 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project 3.d.ii – Expansion of asthma home-based self-management program

IPQR Module 3.d.ii.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

We have identified several risks to this project. The first is the capacity to provide a comprehensive home-based intervention. As we described in our application, there are a number of existing resources, such as NYC's Healthy Homes program or a.i.r. NYC, to support implementation of this program. Given that a number of other PPSs have selected the asthma-home based project, we are concerned that these resources will not be sufficient to meet the needs of the attributed population. To mitigate this risk, we have identified several strategies. First, we are assessing the capacity of our partners to determine where additional capacity may exist. Second, we are identifying opportunities to support partners to develop capacity. Third, we intend to develop a strategy to recruit and train community health workers. Finally, we are coordinating implementation with other PPSs where feasible to establish community resources to do integrated pest management to reduce environmental triggers.

We also anticipate risks associated with the challenge of patient retention in home-based programs. To mitigate this risk our PPS is considering whether to make available patient incentives related to trigger remediation (e.g., pillow cases) in order to improve retention.

The final risk we have identified relates to health IT. While this intervention is primarily home-based and can leverage the use of non-clinical workers, there is also a need to connect with the emergency department (ED) so that when patients are discharged, a root cause analysis of the ED admission can be performed. Connectivity with primary care will also be important in order to support patients in following their asthma action plan, among other activities. We are concerned that the current degree of connectivity – particularly among some of our community-based partners, -- may not sufficiently support data sharing as needed to be effective. To mitigate this risk we have begun to assess partner health IT capabilities and we have established a set of IT requirements related to all DSRIP projects. Once we have completed a detailed landscape assessment, we will develop an approach to deploying IT and providing implementation and training support to address partner needs in order of priority.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.d.ii.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY4,Q4	7,595

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	760	1,519	2,279	3,038
	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Warning: PPS Reported - Please note that your patients engaged to date (0) does not meet your committed amount (760) for 'DY2,Q1'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
chengc2	Rosters	52_DY2Q1_PROJ3dii_MDL3dii2_PES_ROST_20160802_3dii_Asthma_Submission_0_4881.xlsx	DY2 Q1 Project 3.d.ii Patient Engagement Roster	08/02/2016 04:48 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

Community health worker visits to patients' homes have been initiated at one NYC Health + Hospitals facility, including services by newly hired community health workers dedicated to this project. Ongoing community health worker services, including home visits, are taking place at a second facility. OneCity Health anticipates expanding the community health worker program as multiple community-based partners contract to provide the services. A distinct Schedule B for the Asthma project are expected to be executed by partners shortly. The PPS did not request engagement metric reporting from its frontline and reporting teams at this time, because it was not feasible to achieve the metric target under the revised definition issued by NYS DOH.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.d.ii.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Develop Asthma Baseline / Readiness Assessment Survey to identify available community medical and social service providers within the geographic areas, and understand PPS capacity for assessing patients' homes and educating patients on self-management of asthma. Educate partners and roll out survey.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Use Community Needs Assessment (CNA) data and other data sources to target areas of highest need for asthma home-based self-management program.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Develop an Asthma Task Force in collaboration and partnership with community's medical, social and other services providers. The Task Force will develop and update strategies for implementation, monitoring and evaluation on an ongoing basis/as needed.		Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Identify/develop evidence-based best practice protocols/standards for patient's home environmental assessment and home-based patient asthma self-management.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Develop / update contracts with partners to provide patient home environmental assessments, to identify asthma triggers. Develop / update contracts with partners to provide		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
patient home environmental interventions, to remediate those environmental triggers.										
Task Step 6: Define PPS training needs for protocols on patient self-management and protocols for clinical providers and health educators / CHW / Care Managers. Develop curriculum for training. Identify training resources, create training plan, and launch training plan. Coordinate with collaborating PPSs, as appropriate.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 7: Pilot home visits and follow-ups. Monitor performance, including rosters of patients who have received home-based interventions. Refine and roll out program across PPS.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: The Asthma Task Force will convene a Clinical Leadership Team to define PPS-wide guidelines for evidence-based trigger reduction interventions. These interventions would target specifically indoor environmental management of asthma. The team will be represented with participants from multidisciplinary areas of expertise (e.g., physicians, nurses, health educators, community health workers, healthy homes, pest management, smoking counselors, social workers, legal services, NYC-DOHMH, NYCHA).		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Synthesize intervention guidelines and obtain input from the baseline/readiness survey.		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on intervention guidelines, including process and workflow, to monitor proper implementation and compliance with the guidelines for connecting clients to resources		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
for trigger reduction interventions.										
Task Step 4: Refine intervention guidelines through Hub-based planning process and Asthma Task Force committee meetings.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Define and monitor PPS-wide and hub-based training needs for intervention program, including providers and CBOs.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Identify/Develop evidence-based, best practice education and training materials for intervention protocols for indoor trigger reductions.		Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Launch and roll out training program.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop and implement evidence-based asthma management guidelines.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for evidence-based asthma management.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Synthesize asthma management guidelines and obtain input from the baseline/readiness survey. Coordinate with collaborating PPSs, as appropriate.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on asthma management guidelines.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Refine asthma management guidelines through Hub-based planning process and Asthma Task Force committee meetings.		Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Monitor application of management guidelines. Periodically evaluate and revise as needed.		Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that	DY2 Q4	Project	N/A	In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Define PPS patients' training needs for self-management including environmental assessment and self-monitoring.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Identify/Develop curriculum for training and education in asthma self-management.		Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Identify/Develop training resources (including online-web based) and create training plans that include patient outreach incentives, patient education materials, and patient self-monitoring tools.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Incorporate plan and materials into a pilot project before broader rollout.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Monitor training program, including the number of patients trained in both one-on-one sessions and in group sessions.		Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed and conducted training of all providers, including social services and support.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
self-management.										
Task Step 1: Determine IT infrastructure needed to support asthma patient identification and tracking and asthma care coordination.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification, tracking, and coordination.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Identify care teams that include nursing staff, pharmacists, dieticians, community health workers, and social service providers and develop care coordination workflows as part of hub-based planning process.		Project		Completed	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Define care team training needs for delivering coordinated care to the PPS's asthma patients and for using CCMS and related registries.		Project		Completed	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Develop curriculum for training care teams in coordinated care of asthma patients and the use of CCMS and related registries; identify training resources and create training plans.		Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Launch and roll out asthma coordinated care training program.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Complete deployment of CCMS and related registries to support asthma patient identification and tracking.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Monitor application of coordinated care guidelines and refine as needed.		Project		In Progress	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for periodic follow-up services and for root cause		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
analysis methodology for patients discharge from the ED and inpatient units.										
Task Step 2: Synthesize guidelines for periodic follow-up services and for root cause analysis and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on follow-up guidelines.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Refine follow-up guidelines through Hub-based planning process and Asthma Task Force committee meetings.		Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Determine IT infrastructure needed to support patient identification and tracking.		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to assess PPS's level of coordination with Medicaid Managed Care plans, Health Home care managers, PCPs, and specialty providers.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Analyze current state baseline data to assess existing clinical provider capabilities in the treatment of asthma patients. Segment providers. Review current national and state baseline data to identify existing community programs and their scope of services.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify roles, responsibilities, and processes along the continuum of care for asthma patients and any coverage-related		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
gaps.										
Task Step 4: Establish contracts with partners that address services for patients with asthma and related health issues.		Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Establish agreements with MCOs that address coverage of patients with asthma health issues.		Project		In Progress	01/01/2017	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll out training program on interim tracking process.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Monitor implementation of interim tracking process and refine as needed.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Develop CCMS specifications and software requirements:		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.										
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Develop CCMS training requirements.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	
Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	
Develop and implement evidence-based asthma management guidelines.	
Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	
Ensure coordinated care for asthma patients includes social services and support.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	
Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.d.ii.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment narrative	wy622871	Other	52_DY2Q1_PROJ3dii_MDL3dii4_PPS1597_OTH_2a_Mid-Point_Assessment_Project_Narrative_Template_Asthma_vf_5081.pdf	Mid-Point Assessment narrative - Asthma	08/03/2016 02:49 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.d.ii.5 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project 3.g.i – Integration of palliative care into the PCMH Model

IPQR Module 3.g.i.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

Our PPS has extensive palliative care resources. For example, each of the 12 hospitals has palliative care experts who serve a broad range of patient needs. In contrast, our PPS is very limited in terms of the palliative care that is provided in a primary care or patient centered medical home (PCMH) setting. The primary risk we anticipate encountering is the ability of very busy primary care practices to integrate generalist palliative care services and education into their practice. This is due to sometimes short patient visits, workflow changes and data collection (e.g., advanced care directives), managing care transitions, and the need to establish new referral patterns. Our PPS will mitigate this risk by providing standardized training and materials to both providers and other members of the care team, as well as making available an enterprise-wide care management platform. In addition, we will explore the possibility of hiring specially trained physician extenders to support patients' palliative care needs.

Another significant risk involves the requirement that project outcomes be measured using the NY UAS tool. For engaged patients not enrolled in a Managed Long Term Care program, this requirement places a significant burden on the PPS to conduct extensive UAS assessments twice per year for the purpose of collecting outcome measures. In order to administer the UAS, a provider must go through ~40 hours of training, and the assessment itself takes several hours to administer. OneCity Health will attempt to mitigate this risk by working with the State and other impacted PPSs to design an alternative solution for outcome metric collection; we will also leverage providers within our network with existing experience and capacity in administering the UAS.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.g.i.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY4,Q4	11,789

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	1,179	2,358	3,537	4,715
	Quarterly Update	2,142	0	0	0
	Percent(%) of Commitment	181.68%	0.00%	0.00%	0.00%
IA Approved	Quarterly Update	0	0	0	0
	Percent(%) of Commitment	0.00%	0.00%	0.00%	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
chengc2	Rosters	52_DY2Q1_PROJ3gi_MDL3gi2_PES_ROST_20160802_3gi_Palliative_Care_Submission_2142_4883.xlsx	DY2 Q1 Project 3.g.i Patient Engagement Roster	08/02/2016 04:50 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

During DY2 Q1, OneCity Health engaged 2,142 patients in project 3.g.i.

All patients engaged have received palliative care services at participating PCMH sites, in accordance with the adopted clinical guidelines.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.g.i.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand primary care network PCMH certification status and capacity/readiness for palliative care integration. Educate partners on PRAT and roll out PRAT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Analyze current state baseline data to assess existing provider capabilities for implementing evidence-based strategies for integration of palliative care and achieving 2014 Level 1 NCQA PCMH certification. Segment providers.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify roles, responsibilities, and processes for integration of palliative care protocols; sign agreements with identified providers.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
supports and services into the PCP practice.										
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to identify community and provider resources to bring palliative care supports and services into primary care practices. Educate partners on PRAT and roll out PRAT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Analyze current state baseline data to assess existing provider capabilities provide palliative care supports and services. Segment providers.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify roles, responsibilities, and processes for community and provider organizations related to the integration of palliative care into the primary care setting.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Contract with partners as needed.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for integration of palliative care protocols into the primary care setting.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Synthesize guidelines for integration of palliative care and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for palliative care		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
integration.										
Task Step 4: Refine guidelines for palliative care integration through Hub-based planning process.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Roll out and monitor the implementation of palliative care integration. Revise as needed.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	DY2 Q4	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Define PPS provider training needs for enhancing competence in palliative care skills and protocols.		Project		Completed	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop curriculum for training and education in palliative care protocols tailored to the primary care setting.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Identify training resources and create training plan.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Launch and roll-out palliative care training plan		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Monitor training program, including the number of providers trained.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	DY3 Q4	Project	N/A	In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Review existing MCO contracts to determine gaps in coverage related to palliative care.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Develop agreements to address coverage gaps.		Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 3: Finalize agreements with MCO partners.		Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	DY2 Q4	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll out training program on interim tracking process.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Monitor implementation of interim tracking process and refine as needed.		Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.		Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Develop CCMS training requirements.		Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.		Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	
Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	
Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	
Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	
Engage with Medicaid Managed Care to address coverage of services.	
Use EHRs or other IT platforms to track all patients engaged in this project.	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.g.i.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment narrative	wy622871	Other	52_DY2Q1_PROJ3gi_MDL3gi4_PPS1598_OTH_2a_Mid-Point_Assessment_Project_Narrative_Template_PallCare_vf_5084.pdf	Mid-Point Assessment narrative - Palliative Care	08/03/2016 02:51 PM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.g.i.5 - IA Monitoring

Instructions :

Project 4.a.iii – Strengthen Mental Health and Substance Abuse Infrastructure across Systems

IPQR Module 4.a.iii.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

1. Silos between Substance Abuse and Mental Health Services: One risk that OneCity Health confronts is that programs may not be able to overcome the existing silos between substance abuse and mental health services, and hence will primarily focus on mental health needs, while overlooking substance use needs. The CNA identified pronounced silos in care, despite the co-morbidities of MHSA conditions. Further, various evidence-based trainings focus exclusively on mental health concerns. To mitigate this risk, OneCity Health and its MHSA Collaborative Workgroup PPS partners– Bronx Partners for Healthy Communities, Community Care of Brooklyn, and Bronx Health Access–have agreed to build substance use trainings and materials that address prevention of overdose and unprotected sex and other risky behaviors into core programming. Additionally, the Workgroup includes substance use and mental health experts who will continue to ensure that the project addresses both needs in an integrated manner, and also addresses MHSA needs holistically, together with other health needs.

2. Partnership with the Department of Education: Another risk is that PPS partners will not be able to forge a constructive partnership with the Department of Education (DOE) in order to successfully pursue the school-based interventions. The PPSs have identified strong synergies between this project and DOE programming, such as DOE's investments in mental health infrastructure in approximately 100 community/renewal schools city-wide, but they will need to actively engage DOE to succeed in DSRIP-related transformations. The Workgroup has already been addressing this risk by engaging the Director of School Mental Health Services with the City's Office of School Health and individuals with the New York City Department of Health and Mental Hygiene (DOHMH) as advisory members of the Workgroup. The PPS partners will continue to engage both DOE and DOHMH in developing their approach to programming and staffing.

3. Measurement and Sustainability: Additional risks are that PPSs will lack the robust data set required to measure progress against goals and serve as an evidence base to demonstrate the cost-effectiveness of the activities and, relatedly, that MHSA activities will not be sustainable beyond the demonstration period. The PPSs will address these risks in several ways. First, the intervention aims to develop long-standing, sustainable school-based infrastructure to address MHSA needs. The project design utilizes cost-effective staffing plans and trainings to prepare non-MD school-based staff to serve as effective coaches. Further, the PPSs have committed to working together to build an evidence base to document results and cost-effectiveness. The PPSs have identified certain performance metrics, such as reductions in schools suspensions and 911 calls that they will track during the intervention. They will engage MCOs, SDOH, and DOE in discussions regarding the program's cost-effectiveness and how to finance DSRIP staff and their related school-based activities like "coaching" and referrals under a value based payment system post-DSRIP.

4. Engagement of School Staff: Another possible risk is that school-based staff will be disengaged, based on their own biases or misunderstanding of MHSA-related disease, or fears of being held responsible for individual student outcomes related to MHSA issues. To mitigate this risk, PPSs will build partnerships with teachers and school staff at the ground level. Staff trainings will address issues like bias and stigma and will educate staff about the nature of MHSA conditions. The PPSs will also train school-based staff on when to refer students with potentially more serious problems to available referral channels and help to ensure warm handoffs to appropriate community-based MHSA services.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.a.iii.2 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 1. Organize and convene citywide MHSA Workgroup meetings	Completed	1. Organize and convene citywide MHSA Workgroup meetings	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Form MHSA Work Group composed of representatives of the four collaborating PPSs, including community-based representatives	Completed	Form MHSA Work Group composed of representatives of the four collaborating PPSs, including community-based representatives	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify PPS subject matter experts to join Work Group	Completed	Identify PPS subject matter experts to join Work Group	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Invite representatives from DOE-affiliated Office of School Health and DOHMH to join Workgroup as advisory members	Completed	Invite representatives from DOE-affiliated Office of School Health and DOHMH to join Workgroup as advisory members	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Convene Citywide MHSA Workgroup meetings under the standing structure	Completed	Convene Citywide MHSA Workgroup meetings under the standing structure	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Milestone 2. Establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	Completed	2. Establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Confirm commitment of four collaborating PPSs to partner in City-wide implementation of MHSA Project	Completed	Confirm commitment of four collaborating PPSs to partner in City-wide implementation of MHSA Project	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop governance structure and process among collaborating PPSs to oversee the implementation and ongoing operation of the MHSA project, and document functions, roles, and responsibilities for parties including Workgroup	Completed	Develop governance structure and process among collaborating PPSs to oversee the implementation and ongoing operation of the MHSA project, and document functions, roles, and responsibilities for parties including Workgroup	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone 3. Review existing programs and CBOs providing	Completed	3. Review existing programs and CBOs providing MHSA services, as well as adaptations of CC based model.	06/30/2015	03/31/2016	06/30/2015	03/31/2016	03/31/2016	DY1 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
MHSA services, as well as adaptations of CC based model.								
Task Conduct baseline analysis of existing programs and CBOs providing MHSA services to adolescents in schools	Completed	Conduct baseline analysis of existing programs and CBOs providing MHSA services to adolescents in schools	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Review evidence-based adaptations of Collaborative Care (CC) model that have targeted adolescents	Completed	Review evidence-based adaptations of Collaborative Care (CC) model that have targeted adolescents	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Incorporate findings into MHSA project concept document	Completed	Incorporate findings into MHSA project concept document	06/30/2015	03/31/2016	06/30/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone 4. Develop detailed MHSA project operational plan for Collaborative Care Adaptation in schools	Completed	4. Develop detailed MHSA project operational plan for Collaborative Care Adaptation in schools	04/01/2015	03/31/2017	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Engage MHSA Workgroup to develop concept paper describing the approach to strengthening the MHSA infrastructure in schools	Completed	Engage MHSA Workgroup to develop concept paper describing the approach to strengthening the MHSA infrastructure in schools	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Design/implement process to select well qualified Lead Agency to manage detailed program planning and implementation of the MHSA initiative	Completed	Design/implement process to select well qualified Lead Agency to manage detailed program planning and implementation of the MHSA initiative	06/30/2015	09/30/2015	06/30/2015	09/30/2015	09/30/2015	DY1 Q2
Task Contract with selected Lead Agency to manage all aspects of the MHSA project including developing operational plan, selection of community mental/behavioral health agencies, selection of target schools, project staffing structure, and training curriculum	Completed	Contract with selected Lead Agency to manage all aspects of the MHSA project including developing operational plan, selection of community mental/behavioral health agencies, selection of target schools, project staffing structure, and training curriculum	07/31/2015	12/31/2015	07/31/2015	12/31/2015	12/31/2015	DY1 Q3
Task Develop draft operational plan for MHSA Workgroup review that incorporates development of culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation, staffing, training, and referral planning, as needed	Completed	Develop draft operational plan for MHSA Workgroup review that incorporates development of culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation, staffing, training, and referral planning, as needed	07/31/2015	03/31/2016	07/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize draft operational plan and budget; share	Completed	Finalize draft operational plan and budget; share with MHSA Collaborative PPS Governance body for approval	07/31/2015	06/30/2016	07/31/2015	06/30/2016	06/30/2016	DY2 Q1

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
with MHSA Collaborative PPS Governance body for approval								
Milestone 5. Implement Collaborative Care (CC) Adaptation in schools	In Progress	5. Implement Collaborative Care (CC) Adaptation in schools	06/30/2015	09/30/2017	06/30/2015	09/30/2017	09/30/2017	DY3 Q2
Task Design and implement process to select and contract with community mental/behavioral agencies to implement programs in the schools	Completed	Design and implement process to select and contract with community mental/behavioral agencies to implement programs in the schools	07/31/2015	06/30/2016	07/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Solicit DOE input on school selection methodology	In Progress	Solicit DOE input on school selection methodology	07/31/2015	09/30/2017	07/31/2015	09/30/2017	09/30/2017	DY3 Q2
Task Identify target schools for implementation of CC adaptation	In Progress	Identify target schools for implementation of CC adaptation	07/31/2015	06/30/2017	07/31/2015	06/30/2017	06/30/2017	DY3 Q1
Task Develop schedule for MHSA Project activities, including activities preparatory to launch of CC adaptation in schools such as contracting, staff recruitment and deployment, training	In Progress	Develop schedule for MHSA Project activities, including activities preparatory to launch of CC adaptation in schools such as contracting, staff recruitment and deployment, training	07/31/2015	03/31/2017	07/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Launch implementation of MHSA Project CC adaptation in schools	In Progress	Launch implementation of MHSA Project CC adaptation in schools	07/31/2015	09/30/2017	07/31/2015	09/30/2017	09/30/2017	DY3 Q2
Milestone 6. Design young adult-interfacing MHSA programs (for those ages 21-25 yrs)	In Progress	6. Design young adult-interfacing MHSA programs (for those ages 21-25 yrs)	07/31/2015	03/31/2018	07/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Identify target young adult groups, potentially including community college students	In Progress	Identify target young adult groups, potentially including community college students	07/31/2015	03/31/2017	07/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Refine MHSA intervention to integrate programming to reach these young adult groups, including by developing culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation plan, and staffing and training plans	In Progress	Refine MHSA intervention to integrate programming to reach these young adult groups, including by developing culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation plan, and staffing and training plans	07/31/2015	03/31/2018	07/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Launch young adult programs	In Progress	Launch young adult programs	07/31/2015	03/31/2018	07/31/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
4. Develop detailed MHSA project operational plan for Collaborative Care Adaptation in schools	jwarrick	Other	52_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1116_OTH_MHSA_Project_Selection_Committee_Recommendation_4904.pdf	Mental Health & Substance Abuse Selection Committee Recommendation	08/02/2016 05:56 PM
	jwarrick	Documentation/Certification	52_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1116_DOC_Attachment_1_JBFCS_FINAL_SUBMISSION_4903.PDF	Mental Health & Substance Abuse Infrastructure Project Application	08/02/2016 05:54 PM
Mid-Point Assessment narrative	jwarrick	Other	52_DY2Q1_PROJ4aiii_MDL4aiii2_PPS1599_OTH_2a_Mid-Point_Assessment_Project_Narrative_Template_MHSA_vf1_5641.pdf	Mid-Point Assessment narrative - 4.a.iii	08/05/2016 11:58 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1. Organize and convene citywide MHSA Workgroup meetings	
2. Establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	
3. Review existing programs and CBOs providing MHSA services, as well as adaptations of CC based model.	
4. Develop detailed MHSA project operational plan for Collaborative Care Adaptation in schools	The workgroup developed a project concept document incorporating findings from its review of existing resources and programs, including gaps in care. The project concept document was reviewed by the workgroup, with input from representatives of Department of Health and Mental Hygiene (DOHMH), Office of School Health (OSH), and Department of Education (DOE). This project concept document was also reviewed by each PPS, including PPS leadership, along with a recommended plan from the workgroup to consider selecting a lead agency to manage the project, and to consider forming a city-wide governance group by the four PPSs involved. These recommendations were agreed to by leadership at each PPS involved. A selection process was then put in place by the PPSs, which included a request for proposal (RFP) for lead agency selection. On July 6, 2015, the four PPSs pursuing the mental health and substance abuse (MHSA) project (4.a.iii) issued an RFP in order to identify a Lead Agency, and identified two representatives to serve on an eight-person Selection Committee to review and select the Lead Agency. This committee selected a qualified lead agency, Jewish Board for Family and Children's Services (JBFCS). JBFCS's proposal included partnering with the New York Academy of Medicine (NYAM) to manage the project. The JBFCS project proposal was reviewed by the selection committee, and modified based on comments on the proposal. Their proposal was developed from the workgroup's project concept document, and included a detailed operational plan, project staffing and training curriculum, and selection process for schools and community based agencies. The proposal incorporated culturally and linguistically sensitive MEB health promotion and prevention resources. JBFCS finalized the operational plan and budget, and this was approved at the cross-PPS Governance body meeting convening the four PPSs on May 20, 2016.
5. Implement Collaborative Care (CC) Adaptation in schools	
6. Design young adult-interfacing MHSA programs (for those ages 21-25 yrs)	
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.a.iii.3 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project 4.c.ii – Increase early access to, and retention in, HIV care

IPQR Module 4.c.ii.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

The most significant risk we anticipate is the complexity of HIV and the need to focus simultaneously on the medical and social needs of patients given the history of stigma, discrimination and neglect related to the populations most impacted by the HIV epidemic and complicated by commonly co-occurring risk factors among this population (e.g., poverty, unmet behavioral health needs). To meet DSRIP goals, we must work against negative social determinants to create environments where patients receive the care needed to protect their health. This risk cannot be mitigated by one or two strategies, but must be a core component of all efforts.

Additionally, we will seek to improve service delivery to support a more welcoming and understanding environment. For example, we intend to emphasize working with community partners that can provide targeted support and outreach related to a specific population (e.g., transgender women) or related to a specific need (e.g., homelessness) and to focus on cultural competencies and integrating peers in various aspects of care. We will seek to improve the tools we have to better identify characteristics that predict delayed entry into care and significant challenges to reaching and maintaining viral load suppression. By building a better identification system, removing barriers that deter patients from seeking and accepting assistance, and by expanding our coordination with community partners we will mitigate the challenges posed by the complex network of obstacles that put individuals at high risk for HIV acquisition and preclude efforts to engage them and have them retained in HIV care.

Another risk we have identified is the collaboration between 4.c.ii and other DSRIP projects within the OneCity Health PPS. This includes a minimum of four elements; the first two are the logistical timing of intervention activities and the need to shape HIV-specific efforts within an evolving healthcare delivery system. The last two are the desire to support the success of the whole of DSRIP in an effort to strengthen the HIV response and the need to maximize resources related to workforce and IT to avoid duplication while ensuring that adequate resources are allocated to individual projects. Our strategy to mitigate this risk is to focus on approaches that we know work, including ensuring that HIV efforts function as part of a larger network of services and leveraging the model of HIV patient-centered care and co-location of services. We will build upon our strong network of HHC HIV providers and the "hub system" that has been established by OneCity Health to support communication across our PPS.

The need to extend collaborative efforts beyond our PPS multiplies the coordination risks related to OneCity Health. To meet our shared goals, we must collaborate across all PPSs with overlapping service areas. To mitigate this risk, we intend to continue to convene the 4.c.ii PPS HIV Collaborative we established. To our advantage is a long history of working with community campaigns and consortia that address different aspects of HIV care and prevention, such as the New York State Quality of Care Committee, the National Quality Center, HRSA's NYC Ryan White Part A Planning Council, the CDC HIV Prevention Planning Group, and CBO networks.

Finally, we will leverage the PPS HIV Collaborative throughout the next five years by continuing to meet with providers, colleagues and stakeholders to ensure that we share best practices, make progress toward alignment of common language and approaches whenever possible in order to promote a consistent standard for HIV providers across the city.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.c.ii.2 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 1. Convening a PPS HIV Learning Collaborative	In Progress	1. Convening a PPS HIV Learning Collaborative	07/01/2015	03/31/2020	07/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1: Confirm PPS participation in HIV Collaborative throughout DSRIP implementation.	Completed	Step 1: Confirm PPS participation in HIV Collaborative throughout DSRIP implementation.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Contract with DOHMH to convene and support the HIV Collaborative.	In Progress	Step 2: Contract with DOHMH to convene and support the HIV Collaborative.	07/01/2015	06/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Develop agenda for Learning Collaborative meetings and hold meetings.	In Progress	Step 3: Develop agenda for Learning Collaborative meetings and hold meetings.	01/01/2016	03/31/2020	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone 2. Establishing a work plan and timeline for project implementation.	In Progress	2. Establishing a work plan and timeline for project implementation.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop work plan and timeline for projects being implemented jointly across multiple PPSs.	In Progress	Step 1: Develop work plan and timeline for projects being implemented jointly across multiple PPSs.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Develop work plan and timeline for additional projects being implemented by OneCity Health.	In Progress	Step 2: Develop work plan and timeline for additional projects being implemented by OneCity Health.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Validate work plans and timelines with PPS governance bodies and relevant stakeholders, as needed.	In Progress	Step 3: Validate work plans and timelines with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone 3. Developing agreed upon milestones for project implementation.	In Progress	3. Developing agreed upon milestones for project implementation.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Agree on voting guidelines and procedures that will support a transparent, consensus-driven process to reach agreement on project milestones across a diverse set of stakeholders	Completed	Step 1: Agree on voting guidelines and procedures that will support a transparent, consensus-driven process to reach agreement on project milestones across a diverse set of stakeholders	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 2: Develop and discuss set of possible milestones for projects being implemented jointly across multiple PPSs.	In Progress	Step 2: Develop and discuss set of possible milestones for projects being implemented jointly across multiple PPSs.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Reach consensus on cross-PPS milestones based on agreed-upon voting/decision-making process	In Progress	Step 3: Reach consensus on cross-PPS milestones based on agreed-upon voting/decision-making process	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Develop milestones for additional projects being implemented by OneCity Health.	In Progress	Step 4: Develop milestones for additional projects being implemented by OneCity Health.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5: Validate milestones with PPS governance bodies and relevant stakeholders, as needed.	In Progress	Step 5: Validate milestones with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone 4. Agree-on project commonalities and shared resources.	In Progress	4. Agree-on project commonalities and shared resources.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine 4.c.ii projects that are common across most/all PPSs in the Collaborative and a structure for sharing resources needed for implementation.	Completed	Step 1: Determine 4.c.ii projects that are common across most/all PPSs in the Collaborative and a structure for sharing resources needed for implementation.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Validate agreement with PPS governance bodies and relevant stakeholders, as needed.	In Progress	Step 2: Validate agreement with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone 5. Agree-on a data sharing system to address reporting and implementation needs.	In Progress	5. Agree-on a data sharing system to address reporting and implementation needs.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine system for sharing information across PPS and validate decision with PPS governance bodies and relevant stakeholders, as needed.	In Progress	Step 1: Determine system for sharing information across PPS and validate decision with PPS governance bodies and relevant stakeholders, as needed.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Contract with system developer/administrator, as needed.	In Progress	Step 2: Contract with system developer/administrator, as needed.	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Mid-Point Assessment narrative	Completed	Mid-Point Assessment narrative			04/01/2016	06/30/2016	06/30/2016	DY2 Q1

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Mid-Point Assessment narrative	chengc2	Other	52_DY2Q1_PROJ4cii_MDL4cii2_PPS1600_OTH_2a_Mid-Point_Assessment_Project_Narrative_Template_HIV_vf1_5637.pdf	OneCity Health Mid-Point Assessment narrative - 4.c.ii	08/05/2016 11:55 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1. Convening a PPS HIV Learning Collaborative	The HIV Collaborative has drafted a Memorandum of Agreement (MOA) between the participating PPSs and the New York City Department of Health and Mental Hygiene (DOHMH) outlining the role of DOHMH as conveyor of the HIV Collaborative. The HIV Collaborative has convened throughout the MOA drafting and completion process. DOHMH is producing a final version of the MOA, which is expected to be fully executed by the end of August. In response, the end date for step 2 of milestone 1 is being changed to DY2 Q2.
2. Establishing a work plan and timeline for project implementation.	
3. Developing agreed upon milestones for project implementation.	
4. Agree-on project commonalities and shared resources.	
5. Agree-on a data sharing system to address reporting and implementation needs.	
Mid-Point Assessment narrative	The Mid-Point Assessment narrative is attached.

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.c.ii.3 - IA Monitoring

Instructions :

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Attestation

The Lead Representative has been designated by the Primary Lead PPS Provider (PPS Lead Entity) as the signing officiate for the DSRIP Quarterly Report. The Lead Representative has the authority to complete this attestation on behalf of the PPS network. The Lead Representative and PPS Lead Entity are responsible for the authenticity and accuracy of the material submitted in this report.

The Lead Representative of the Performing Provider System (PPS) must complete this attestation form in order for the project application to be accepted by the NYS Department of Health. Once the attestation is complete, the Quarterly Report will be locked down from any further editing. Do not complete this section until the entire Quarterly Report is complete.

If the Quarterly Report becomes locked in error and additional changes are necessary, please use the contact information on the Home Page to request that the Quarterly Report be unlocked.

To electronically sign this Quarterly Report, please enter the required information and check the box below:

☐ **I here by attest, as the Lead Representative of the 'New York City Health and Hospitals Corporation ', that all information provided on this Quarterly report is true and accurate to the best of my knowledge, and that, following initial submission in the current quarterly reporting period as defined by NY DOH, changes made to this report were pursuant only to documented instructions or documented approval of changes from DOH or DSRIP Independent Assessor.**

Primary Lead PPS Provider:	JACOBI MEDICAL CENTER
Secondary Lead PPS Provider:	
Lead Representative:	Inez Sieben
Submission Date:	09/23/2016 02:05 PM

Comments:

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY2, Q1	Adjudicated	Inez Sieben	mrurak	09/30/2016 03:38 PM

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY2Q1 quarterly report.	mrurak	09/30/2016 03:38 PM
Adjudicated	The IA has adjudicated the DY2Q1 quarterly report.	mrurak	09/30/2016 03:37 PM
Returned	The IA has returned your DY2Q1 Quarterly Report for Remediation.	emcgill	09/02/2016 03:54 PM

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section	Module Name	Status
Section 01	IPQR Module 1.1 - PPS Budget - Waiver Revenue (Baseline) - READ ONLY	Completed
	IPQR Module 1.2 - PPS Budget - Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.3 - PPS Flow of Funds - Waiver Revenue (Baseline) - READ ONLY	Completed
	IPQR Module 1.4 - PPS Flow of Funds - Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.5 - Prescribed Milestones	Completed
	IPQR Module 1.6 - PPS Defined Milestones	Completed
	IPQR Module 1.7 - PPS Budget - Non-Waiver Revenue (Baseline)	Completed
	IPQR Module 1.8 - PPS Budget - Non-Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.9 - PPS Flow of Funds - Non-Waiver Revenue (Baseline)	Completed
	IPQR Module 1.10 - PPS Flow of Funds - Non-Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.11 - IA Monitoring	
Section 02	IPQR Module 2.1 - Prescribed Milestones	Completed
	IPQR Module 2.2 - PPS Defined Milestones	Completed
	IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 2.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 2.5 - Roles and Responsibilities	Completed
	IPQR Module 2.6 - Key Stakeholders	Completed
	IPQR Module 2.7 - IT Expectations	Completed
	IPQR Module 2.8 - Progress Reporting	Completed
	IPQR Module 2.9 - IA Monitoring	
Section 03	IPQR Module 3.1 - Prescribed Milestones	Completed
	IPQR Module 3.2 - PPS Defined Milestones	Completed
	IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 3.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 3.5 - Roles and Responsibilities	Completed
	IPQR Module 3.6 - Key Stakeholders	Completed
	IPQR Module 3.7 - IT Expectations	Completed

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section	Module Name	Status
	IPQR Module 3.8 - Progress Reporting	Completed
	IPQR Module 3.9 - IA Monitoring	
Section 04	IPQR Module 4.1 - Prescribed Milestones	Completed
	IPQR Module 4.2 - PPS Defined Milestones	Completed
	IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 4.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 4.5 - Roles and Responsibilities	Completed
	IPQR Module 4.6 - Key Stakeholders	Completed
	IPQR Module 4.7 - IT Expectations	Completed
	IPQR Module 4.8 - Progress Reporting	Completed
	IPQR Module 4.9 - IA Monitoring	
Section 05	IPQR Module 5.1 - Prescribed Milestones	Completed
	IPQR Module 5.2 - PPS Defined Milestones	Completed
	IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 5.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 5.5 - Roles and Responsibilities	Completed
	IPQR Module 5.6 - Key Stakeholders	Completed
	IPQR Module 5.7 - Progress Reporting	Completed
	IPQR Module 5.8 - IA Monitoring	
Section 06	IPQR Module 6.1 - Prescribed Milestones	Completed
	IPQR Module 6.2 - PPS Defined Milestones	Completed
	IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 6.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 6.5 - Roles and Responsibilities	Completed
	IPQR Module 6.6 - Key Stakeholders	Completed
	IPQR Module 6.7 - IT Expectations	Completed
	IPQR Module 6.8 - Progress Reporting	Completed
	IPQR Module 6.9 - IA Monitoring	
Section 07	IPQR Module 7.1 - Prescribed Milestones	Completed

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section	Module Name	Status
	IPQR Module 7.2 - PPS Defined Milestones	Completed
	IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 7.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 7.5 - Roles and Responsibilities	Completed
	IPQR Module 7.6 - Key Stakeholders	Completed
	IPQR Module 7.7 - IT Expectations	Completed
	IPQR Module 7.8 - Progress Reporting	Completed
	IPQR Module 7.9 - IA Monitoring	
Section 08	IPQR Module 8.1 - Prescribed Milestones	Completed
	IPQR Module 8.2 - PPS Defined Milestones	Completed
	IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 8.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 8.5 - Roles and Responsibilities	Completed
	IPQR Module 8.6 - Key Stakeholders	Completed
	IPQR Module 8.7 - IT Expectations	Completed
	IPQR Module 8.8 - Progress Reporting	Completed
	IPQR Module 8.9 - IA Monitoring	
Section 09	IPQR Module 9.1 - Prescribed Milestones	Completed
	IPQR Module 9.2 - PPS Defined Milestones	Completed
	IPQR Module 9.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 9.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 9.5 - Roles and Responsibilities	Completed
	IPQR Module 9.6 - Key Stakeholders	Completed
	IPQR Module 9.7 - IT Expectations	Completed
	IPQR Module 9.8 - Progress Reporting	Completed
	IPQR Module 9.9 - IA Monitoring	
Section 10	IPQR Module 10.1 - Overall approach to implementation	Completed
	IPQR Module 10.2 - Major dependencies between work streams and coordination of projects	Completed
	IPQR Module 10.3 - Project Roles and Responsibilities	Completed

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section	Module Name	Status
	IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects	Completed
	IPQR Module 10.5 - IT Requirements	Completed
	IPQR Module 10.6 - Performance Monitoring	Completed
	IPQR Module 10.7 - Community Engagement	Completed
	IPQR Module 10.8 - IA Monitoring	
Section 11	IPQR Module 11.1 - Workforce Strategy Spending (Baseline)	Completed
	IPQR Module 11.2 - Prescribed Milestones	Completed
	IPQR Module 11.3 - PPS Defined Milestones	Completed
	IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 11.5 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 11.6 - Roles and Responsibilities	Completed
	IPQR Module 11.7 - Key Stakeholders	Completed
	IPQR Module 11.8 - IT Expectations	Completed
	IPQR Module 11.9 - Progress Reporting	Completed
	IPQR Module 11.10 - Staff Impact	Completed
	IPQR Module 11.11 - Workforce Strategy Spending (Quarterly)	Completed
	IPQR Module 11.12 - IA Monitoring	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name	Status
2.a.i	IPQR Module 2.a.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.a.i.2 - Prescribed Milestones	Completed
	IPQR Module 2.a.i.3 - PPS Defined Milestones	Completed
	IPQR Module 2.a.i.4 - IA Monitoring	
2.a.iii	IPQR Module 2.a.iii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.a.iii.2 - Patient Engagement Speed	Completed
	IPQR Module 2.a.iii.3 - Prescribed Milestones	Completed
	IPQR Module 2.a.iii.4 - PPS Defined Milestones	Completed
	IPQR Module 2.a.iii.5 - IA Monitoring	
2.b.iii	IPQR Module 2.b.iii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.b.iii.2 - Patient Engagement Speed	Completed
	IPQR Module 2.b.iii.3 - Prescribed Milestones	Completed
	IPQR Module 2.b.iii.4 - PPS Defined Milestones	Completed
	IPQR Module 2.b.iii.5 - IA Monitoring	
2.b.iv	IPQR Module 2.b.iv.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.b.iv.2 - Patient Engagement Speed	Completed
	IPQR Module 2.b.iv.3 - Prescribed Milestones	Completed
	IPQR Module 2.b.iv.4 - PPS Defined Milestones	Completed
	IPQR Module 2.b.iv.5 - IA Monitoring	
2.d.i	IPQR Module 2.d.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.d.i.2 - Patient Engagement Speed	Completed
	IPQR Module 2.d.i.3 - Prescribed Milestones	Completed
	IPQR Module 2.d.i.4 - PPS Defined Milestones	Completed
	IPQR Module 2.d.i.5 - IA Monitoring	
3.a.i	IPQR Module 3.a.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.a.i.2 - Patient Engagement Speed	Completed
	IPQR Module 3.a.i.3 - Prescribed Milestones	Completed

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name	Status
	IPQR Module 3.a.i.4 - PPS Defined Milestones	Completed
	IPQR Module 3.a.i.5 - IA Monitoring	
3.b.i	IPQR Module 3.b.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.b.i.2 - Patient Engagement Speed	Completed
	IPQR Module 3.b.i.3 - Prescribed Milestones	Completed
	IPQR Module 3.b.i.4 - PPS Defined Milestones	Completed
	IPQR Module 3.b.i.5 - IA Monitoring	
3.d.ii	IPQR Module 3.d.ii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.d.ii.2 - Patient Engagement Speed	Completed
	IPQR Module 3.d.ii.3 - Prescribed Milestones	Completed
	IPQR Module 3.d.ii.4 - PPS Defined Milestones	Completed
	IPQR Module 3.d.ii.5 - IA Monitoring	
3.g.i	IPQR Module 3.g.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.g.i.2 - Patient Engagement Speed	Completed
	IPQR Module 3.g.i.3 - Prescribed Milestones	Completed
	IPQR Module 3.g.i.4 - PPS Defined Milestones	Completed
	IPQR Module 3.g.i.5 - IA Monitoring	
4.a.iii	IPQR Module 4.a.iii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 4.a.iii.2 - PPS Defined Milestones	Completed
	IPQR Module 4.a.iii.3 - IA Monitoring	
4.c.ii	IPQR Module 4.c.ii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 4.c.ii.2 - PPS Defined Milestones	Completed
	IPQR Module 4.c.ii.3 - IA Monitoring	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section	Module Name / Milestone #	Review Status	
Section 01	Module 1.1 - PPS Budget - Waiver Revenue (Baseline) - READ ONLY	Pass & Complete	
	Module 1.2 - PPS Budget - Waiver Revenue (Quarterly)	Pass & Ongoing	
	Module 1.3 - PPS Flow of Funds - Waiver Revenue (Baseline) - READ ONLY	Pass & Ongoing	
	Module 1.4 - PPS Flow of Funds - Waiver Revenue (Quarterly)	Pass & Ongoing	
	Module 1.5 - Prescribed Milestones		
	Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Pass & Ongoing	
	Module 1.7 - PPS Budget - Non-Waiver Revenue (Baseline)	Pass & Ongoing	
	Module 1.8 - PPS Budget - Non-Waiver Revenue (Quarterly)	Pass & Ongoing	
	Module 1.9 - PPS Flow of Funds - Non-Waiver Revenue (Baseline)	Pass & Ongoing	
	Module 1.10 - PPS Flow of Funds - Non-Waiver Revenue (Quarterly)	Pass & Ongoing	
Section 02	Module 2.1 - Prescribed Milestones		
	Milestone #1 Finalize governance structure and sub-committee structure	Pass & Complete	
	Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Pass & Complete	
	Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Pass & Complete	
	Milestone #4 Establish governance structure reporting and monitoring processes	Pass & Complete	
	Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Pass & Ongoing	
	Milestone #6 Finalize partnership agreements or contracts with CBOs	Pass (with Exception) & Ongoing	IA
	Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Pass & Complete	
	Milestone #8 Finalize workforce communication and engagement plan	Pass & Ongoing	
	Milestone #9 Inclusion of CBOs in PPS Implementation.	Pass & Ongoing	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1 Finalize PPS finance structure, including reporting structure	Pass & Complete	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section	Module Name / Milestone #	Review Status	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Complete	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Pass & Complete	
	Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Pass & Ongoing	
	Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	Pass & Ongoing	
	Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	Pass & Ongoing	
	Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	Pass & Ongoing	
	Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	Pass & Ongoing	
Section 04	Module 4.1 - Prescribed Milestones		
	Milestone #1 Finalize cultural competency / health literacy strategy.	Pass & Complete	
	Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Pass & Complete	
Section 05	Module 5.1 - Prescribed Milestones		
	Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	Pass & Complete	
	Milestone #2 Develop an IT Change Management Strategy.	Pass & Ongoing	
	Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	Pass & Ongoing	
	Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Pass (with Exception) & Ongoing	
	Milestone #5 Develop a data security and confidentiality plan.	Pass & Ongoing	
Section 06	Module 6.1 - Prescribed Milestones		
	Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	Pass & Ongoing	
	Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	Pass & Ongoing	
Section 07	Module 7.1 - Prescribed Milestones		
	Milestone #1 Develop Practitioners communication and engagement plan.	Pass & Complete	
	Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Pass & Complete	
Section 08	Module 8.1 - Prescribed Milestones		

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section	Module Name / Milestone #	Review Status	
	Milestone #1 Develop population health management roadmap.	Pass & Ongoing	
	Milestone #2 Finalize PPS-wide bed reduction plan.	Pass & Ongoing	
Section 09	Module 9.1 - Prescribed Milestones		
	Milestone #1 Perform a clinical integration 'needs assessment'.	Pass & Complete	
	Milestone #2 Develop a Clinical Integration strategy.	Pass & Ongoing	
Section 11	Module 11.1 - Workforce Strategy Spending (Baseline)	Pass & Complete	
	Module 11.2 - Prescribed Milestones		
	Milestone #1 Define target workforce state (in line with DSRIP program's goals).	Pass & Ongoing	
	Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Pass & Ongoing	
	Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Pass & Ongoing	
	Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Pass & Complete	
	Milestone #5 Develop training strategy.	Pass & Ongoing	
	Module 11.10 - Staff Impact	Pass & Ongoing	
	Module 11.11 - Workforce Strategy Spending (Quarterly)	Pass & Ongoing	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
2.a.i	Module 2.a.i.2 - Prescribed Milestones		
	Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	Pass & Ongoing	
	Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Pass & Ongoing	
	Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Pass & Ongoing	
	Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Pass & Ongoing	
	Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Pass & Ongoing	
	Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Pass & Ongoing	
	Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Pass & Ongoing	
	Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Pass & Ongoing	
	Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Pass & Ongoing	
2.a.iii	Module 2.a.iii.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 2.a.iii.3 - Prescribed Milestones		
	Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	Pass & Ongoing	
	Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	Pass & Ongoing	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
	Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	Pass & Ongoing	
	Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	Pass & Ongoing	
	Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	Pass & Ongoing	
	Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	Pass & Ongoing	
	Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	Pass & Ongoing	
	Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	Pass & Ongoing	
2.b.iii	Module 2.b.iii.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 2.b.iii.3 - Prescribed Milestones		
	Milestone #1 Establish ED care triage program for at-risk populations	Pass & Ongoing	
	Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	Pass & Ongoing	
	Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Pass & Ongoing	
	Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	Pass & Ongoing	
	Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 2.b.iv.3 - Prescribed Milestones		
	Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Pass & Ongoing	
	Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Pass & Ongoing	
	Milestone #3 Ensure required social services participate in the project.	Pass & Ongoing	
	Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Pass & Ongoing	
	Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Pass & Ongoing	
	Milestone #6 Ensure that a 30-day transition of care period is established.	Pass & Ongoing	
	Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.d.i	Module 2.d.i.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 2.d.i.3 - Prescribed Milestones		
	Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	Pass & Ongoing	
	Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Pass & Ongoing	
	Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	Pass & Ongoing	
	Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Pass & Ongoing	
	Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Pass & Ongoing	
	Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	Pass & Ongoing	
	Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for	Pass & Ongoing	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
	each cohort at the beginning of each performance period.		
	Milestone #8 Include beneficiaries in development team to promote preventive care.	Pass & Ongoing	
	Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	Pass & Ongoing	
	Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Pass & Ongoing	
	Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	Pass & Ongoing	
	Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Pass & Ongoing	
	Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Pass & Ongoing	
	Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	Pass & Ongoing	
	Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Pass & Ongoing	
	Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Pass & Ongoing	
	Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	Pass & Ongoing	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
	Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Pass & Ongoing	
	Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Co-locate primary care services at behavioral health sites.	Pass & Ongoing	
	Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	
	Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Pass & Ongoing	
	Milestone #13 Measure outcomes as required in the IMPACT Model.	Pass & Ongoing	
	Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Pass & Ongoing	
	Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.b.i	Module 3.b.i.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 3.b.i.3 - Prescribed Milestones		
	Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Pass & Ongoing	
	Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Pass & Ongoing	
	Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Pass & Ongoing	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
	Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Pass & Ongoing	
	Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Pass & Ongoing	
	Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Pass & Ongoing	
	Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Pass & Ongoing	
	Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Pass & Ongoing	
	Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Pass & Ongoing	
	Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Pass & Ongoing	
	Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Pass & Ongoing	
	Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Pass & Ongoing	
	Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Pass & Ongoing	
	Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Pass & Ongoing	
	Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Pass & Ongoing	
	Milestone #18 Adopt strategies from the Million Hearts Campaign.	Pass & Ongoing	
	Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Pass & Ongoing	
	Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Pass & Ongoing	
3.d.ii	Module 3.d.ii.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 3.d.ii.3 - Prescribed Milestones		
	Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Pass & Ongoing	
	Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Pass & Ongoing	
	Milestone #3 Develop and implement evidence-based asthma management guidelines.	Pass & Ongoing	
	Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma	Pass & Ongoing	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
	symptoms and asthma control, and using written asthma action plans.		
	Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	Pass & Ongoing	
	Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Pass & Ongoing	
	Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.g.i	Module 3.g.i.2 - Patient Engagement Speed	Pass (with Exception) & Ongoing	
	Module 3.g.i.3 - Prescribed Milestones		
	Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Pass & Ongoing	
	Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Pass & Ongoing	
	Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Pass & Ongoing	
	Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Pass & Ongoing	
	Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Pass & Ongoing	
	Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
4.a.iii	Module 4.a.iii.2 - PPS Defined Milestones	Pass & Ongoing	
4.c.ii	Module 4.c.ii.2 - PPS Defined Milestones	Pass & Ongoing	

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Providers Participating in Projects

	Selected Projects										
	Project 2.a.i	**Project 2.a.iii**	**Project 2.b.iii**	**Project 2.b.iv**	**Project 2.d.i**	**Project 3.a.i**	**Project 3.b.i**	**Project 3.d.ii**	**Project 3.g.i**	**Project 4.a.iii**	**Project 4.c.ii**
Provider Speed Commitments	DY4 Q4	DY3 Q4	DY4 Q2	DY3 Q4	DY3 Q2	DY4 Q4	DY3 Q4	DY3 Q4	DY3 Q4		

Provider Category		**Project 2.a.i**		**Project 2.a.iii**		**Project 2.b.iii**		**Project 2.b.iv**		**Project 2.d.i**		**Project 3.a.i**		**Project 3.b.i**		**Project 3.d.ii**		**Project 3.g.i**		**Project 4.a.iii**		**Project 4.c.ii**	
		Selected / Committed		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**	
Practitioner - Primary Care Provider (PCP)	Total	1	1,199	0	779	0	0	0	720	1	0	0	600	0	959	0	300	0	300	0	0	0	0
	Safety Net	1	358	0	232	0	232	0	214	1	125	0	286	0	322	0	125	0	143	0	0	0	0
Practitioner - Non-Primary Care Provider (PCP)	Total	0	4,634	0	231	0	0	0	695	0	0	0	93	0	93	0	93	0	93	0	0	0	0
	Safety Net	0	490	0	24	0	0	0	196	0	48	0	24	0	24	0	24	0	24	0	0	0	0
Hospital	Total	1	15	0	0	0	0	0	7	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	Safety Net	1	14	0	0	0	9	0	9	1	9	0	0	0	0	0	0	0	0	0	0	0	0
Clinic	Total	5	56	0	22	0	0	0	0	7	0	0	28	0	11	0	5	0	5	0	0	0	0
	Safety Net	5	58	0	25	0	25	0	0	7	25	0	31	0	12	0	6	0	6	0	0	0	0
Case Management / Health Home	Total	7	46	0	35	0	0	0	35	1	0	0	0	0	23	0	9	0	0	0	0	0	0
	Safety Net	5	21	0	16	0	16	0	16	1	0	0	0	0	11	0	4	0	0	0	0	0	0
Mental Health	Total	7	538	0	188	0	0	0	0	3	0	0	161	0	10	0	0	0	0	0	0	0	0
	Safety Net	6	164	0	103	0	0	0	0	3	0	0	56	0	3	0	0	0	0	0	0	0	0
Substance Abuse	Total	7	44	0	22	0	0	0	0	0	0	0	19	0	1	0	0	0	0	0	0	0	0
	Safety Net	7	44	0	22	0	0	0	0	0	0	0	19	0	1	0	0	0	0	0	0	0	0
Nursing Home	Total	3	54	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Safety Net	3	55	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy	Total	1	25	0	19	0	0	0	0	1	0	0	0	0	8	0	6	0	0	0	0	0	0
	Safety Net	1	21	0	19	0	0	0	0	1	1	0	0	0	7	0	5	0	0	0	0	0	0
Hospice	Total	3	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0

New York State Department Of Health
Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Provider Category		Project 2.a.i		Project 2.a.iii		Project 2.b.iii		Project 2.b.iv		Project 2.d.i		Project 3.a.i		Project 3.b.i		Project 3.d.ii		Project 3.g.i		Project 4.a.iii		Project 4.c.ii	
		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed	
	Safety Net	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Community Based Organizations	Total	10	88	0	18	0	0	0	18	8	0	0	18	0	18	0	18	0	18	0	0	0	0
	Safety Net	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
All Other	Total	23	2,521	0	126	0	0	0	126	10	0	0	126	0	126	0	50	0	50	0	0	0	0
	Safety Net	18	706	0	20	0	0	0	20	10	35	0	20	0	20	0	14	0	14	0	0	0	0
Uncategorized	Total	5	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	Safety Net	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Additional Providers	Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Safety Net	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Current File Uploads

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